

**USERS' EXPERIENCE OF PRIMARY HEALTHCARE SERVICES AFTER
THE REMOVAL OF USER FEES: A STUDY OF CHELSTONE AND
MTENDERE TOWNSHIPS (2012-2014)**

By

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DECLARATION

I, **Tambulani Chayima Nyirenda** declare that the contents of this dissertation represent my own work, all other works has been duly acknowledged and that the dissertation has not previously been submitted for academic examination towards any qualification.

Signed

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CERTIFICATE OF APPROVAL

This dissertation of **Tambulani Chayima Nyirenda** has been approved as partial fulfilment of the requirement for the award of the Degree of Master of Public Administration by the University of Zambia.

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ABSTRACT

The study sought to investigate the users' experiences of primary healthcare services after the removal of user fees in the urban townships of Mtendere and Chelstone. This is because after the removal of user fees, the experiences of users of primary healthcare services do not seem to be systematically documented. Specific objectives were to: i) Determine whether, after the removal of user fees, users encountered any fees at primary health care centers; ii) Establish the time spent by users at health facilities at primary healthcare centre's; and iii) Examine the extent to which users had access to prescribed drugs at the primary health care centers.

The study used exploratory and descriptive survey designs. It collected both qualitative and quantitative data. The study used a sample size of 260 respondents broken down as follows: 130 residents each from Mtendere and Chelstone townships. The study used a two-stage stratified cluster sample design. Twelve (12) health workers, as key informants, were selected using purposive sampling, six (06) each from the health centers and two district community health officials. Quantitative data collected was analysed using computer generated software, while qualitative data was transcribed into major themes.

The findings revealed that most of the respondents (93.9 percent) were charged for registration. 95.4 percent of the users said they were not charged for consultation. On the average, respondents spent about 2 hours waiting to be attended to by a doctor or clinic officer at the Health Centre. The responses showed that respondents spent more than 48 minutes above the time that users spent before the removal of user fees. Further, the responses revealed that respondents spent about 3 hours as the total time at the health centre. Most respondents (54.6 percent) did not find the drugs at the Health Centre's pharmacy. Due to lack of drugs at health centres, respondents experienced drug cost at private chemists of about K43.8. Three quarters (74.2 percent) of the respondents said there was inadequate staff at the Health Centre they visited.

The study recommended that: i) there is need to ensure there strict adherence to the no fee policy; (ii) There is need to build more health facilities to reduce on the long waiting times and; iii) Emphasis should be placed on ensuring that drug availability is increased since utilisation increased.

DEDICATION

To my parents Herbert B. C. Nyirenda and Violet Z. Banda

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LIST OF ABBREVIATIONS/ACRONYMS

CDEs	-	Classified Daily Employees
CSO	-	Central Statistics Office
CSAs	-	Census Supervisory Area
GDP	-	Gross Domestic Product
HCs	-	Health Centres
HSSREC	-	Humanities and Social Sciences Research Ethics Committee
LDCHO	-	Lusaka District Community Health Office
MoH	-	Ministry of Health
NHSP	-	National Health Strategic Plan
NGOs	-	Non-Governmental Organizations
RHC	-	Rural Health Centre
SEA	-	Standard enumeration Area
UNICEF	-	United Nations International Children's Emergency Fund
UHC	-	Urban Health Centre
WHP	-	World Health Organisation
ZDHS	-	Zambia Demographic and Health Survey

CHAPTER ONE

INTRODUCTION AND BACKGROUND

INTRODUCTION

This chapter focuses on background to the study, statement of the problem, objectives, significance of the study and the conceptual framework. The chapter also includes the literature review and the methodology sections. This chapter, therefore, not only provided information on past documented users experiences but also provided aims and methods in which their experiences, after the removal of user fees, were investigated and documented.

BACKGROUND TO THE STUDY

From 1964 until the early 1990's, the Zambian Government adopted a policy to provide free healthcare services for all Zambians (Sjaak van der Geest et al, 2000). However, from 1967 to the late 1970's and early 1980's, the terms of trade for the price of copper, Zambia's main foreign exchange earner declined. This was coupled with domestic policy failures and the effects of the international oil price shocks of the 1970's. Since the provision of health services was largely contingent on continued resources from the government, the resultant poor economy meant that fewer resources were allocated into the health sector, leading to health conditions deteriorating. Undoubtedly, the economic crisis of the 1970s and 1980s led to a decline in real health expenditure by 41% between 1970 and 1984 (Macwan'gi, Kamwanga, and Mulikelela, 1996, Kasonde and Martin, 1994). Because of the reduced health expenditure, users experienced inadequate health care due to erratic and limited supplies of essential drugs and vaccines, as well as basic supplies and equipment (Kasonde and Martin, 1994). The reduction in health expenditure also resulted in serious shortage of health personnel, presumably, low salaries contributed to high staff turnover. Users, as recipients of healthcare, received poor quality services. It, therefore, became unsustainable to continue providing free health services (Cheelo et al, 2010).

Among other factors, including the economic crisis of the 1970's and 80's, failure to sustainably provide free health services led to the introduction of health reforms in 1993

which called for cost sharing on the part of beneficiaries. User fees were introduced to raise extra revenue, addressing recurrent costs problems, provide a more sustainable health service system and increase efficiency (Masiye, Chitah, Chanda, and Simeo, 2008). User fees implied an out-of-pocket charge at the time of use of health services for the users (Ministry of Health, 1993). An exemption mechanism was designed to be included in the new policy to cater for very needy and vulnerable users. The exempted users included children under five years old, adults above 65 years old and pregnant women (Central Board of Health 2002).

After the introduction of user fees, Lake (1994) reported that there was a decline in patient flows of between 60 to 80 per cent at urban health centre's in Lusaka. Outpatient attendance at eleven clinics surveyed in Lusaka dropped, on average by 64 per cent after the introduction of user fees. The poorest neighbourhoods showed the sharpest declines. Household surveys in 2002 by CSO also showed that across the country about one quarter of patients were turned away from health facilities because they could not afford the user fees. Further, almost one in four patients given a prescription could not afford to buy the medicines (Central Statistics Office, 2002). However, Sjaak van der Geest reported that the drug situation in health centers had somewhat improved with the implementation of user fees. And because drugs were the overriding criterion by which patients judged the quality of health services, healthcare services under the user fee policy were seen to be effective (Sjaak van der Geest et al, 2000).

After 13 years under the user fee regime, Zambia in 2006 discontinued charging user fees through the abolishment of user fees policy in rural and peri-urban areas. The user fees removal policy was then rolled out to all primary health care services across the country in 2012 (Ministry of Health, 2013). Since the removal of some user fees, the Ministry of Health had conducted a number of surveys that show that the utilization of health centers increased from 7 percent to 29 percent across the country (Ministry of Health 2009).

However, the removal of user fees has had differing implications to different populations in the country, thereby resulting in different user experiences. Case studies in rural areas where the abolishment of the user fees policy was first implemented had shown a variety of experiences in healthcare services that were provided free of charge. In some cases, charges still existed for registration and laboratory tests, while it was unclear if patients should pay for admission, surgery or use of ambulance. DFID (2010) reported that users experienced informal charging of user fees, including charges for registration. Some interviews conducted by DFID also showed that in communities, many people did not perceive care to be free of charge.

Overall, the removal of user fees had made working conditions more difficult for health workers because workloads had increased due to the large numbers of users attracted by free services resulting in delay in attending to the users. According to Carasso, et al (2012), health workers reported that there was a significant increase in workload. Some staff reported that this included being called to see patients outside working hours. Removing user fees can also lead to ineffective healthcare such as poor quality of care and non-availability of drugs. In rural areas, the removal of user fees worsened the working conditions as a result of absence of additional resources to deal with the increased demand or replace the loss of revenue generated by fees (Carasso, et al, 2012). Some health facilities located in the most remote areas were found to be especially dependent on the help of classified daily employees (CDEs) to provide care. Some of these facilities had to lay off CDEs after the policy change as these salaries used to be paid for with user fee income. The removal of user fees should, thus, be accompanied by supporting policies, especially by increasing public funding and the efficient distribution of drugs and related supplies (Masiye, Chitah, Chanda, and Simeo, 2008).

Although the removal of user fees resulted in increased utilization of health services, the removal has taken away an important source of financing for health centers which has the potential to hamper effective delivery of health services (Ministry of Health, 2013). Therefore, documenting of patients' experiences of health services after the removal of

user fees can provide organizations with a yard stick against which the quality of their services can be measured (Coulter, 2006).

STATEMENT OF THE PROBLEM

The removal of user fees was meant to ensure that primary healthcare services at all levels are funded from the general tax revenue and provided free of charge to all citizens (MoH, 2013). But, the abolishment of user fees has widened financing gaps at health centers because grants cannot compensate for the lost revenues created by the removal (Ministry of Health, 2012). Urban Health Centre's were particularly highly reliant on user fees financing (Ministry of Health, 2007). The experiences of users of primary healthcare services after the removal of user fees have not been systematically documented. It was thus important to investigate user's experiences of healthcare, specifically, in urban areas where the policy was implemented in 2012. At Chelstone and Mtendere Health Centres, utilization of health services had almost doubled after the removal of user fees, 102, 423 users and 89, 973 users at Chelstone and Mtendere health Centres respectively, but, Urban Health Centres are designed to provide health services to a catchment population of 50, 000 (MoH, 2013).

STUDY OBJECTIVES

Main Objective

To investigate and document the users experience of primary healthcare services after the removal of user fees in the urban townships of Mtendere and Chelstone

Specific Objectives were to:

- i) Determine whether users' encountered any fees at primary health care centers
- ii) Establish the time spent by users at health facilities
- iii) Examine the extent to which users had access to prescribed drugs at the primary health care centers

SIGNIFICANCE OF THE STUDY

User's experiences of the health care delivery affects the utilization of health facilities and services being offered. It is therefore necessary to understand users' experiences because they provide valuable information that can be used in screening for problems and developing an effective plan of action for quality improvement of health care delivery.

The results of the study will assist in decision making related to patient flow management in order to reduce patient waiting time which in turn will improve access to healthcare services and reduce overcrowding. The information collected in this study will be useful to policy makers on the effects of removal of user fees on health care delivery.

User's, through their unique experience, can offer insights into health service quality that would be unseen from other perspectives, such as the way a treatment, process or interaction has made them feel and, subsequently, behave. There is also increasing evidence that patients who have positive health care experiences have improved outcomes resulting in a more efficient health care system (Sofaer and Firminger, 2005). The necessity to get the users' perspective is not new. However, recent aspirations for person-centred care and 'mutual' health care services have reaffirmed the imperativeness for clinicians and health care managers to listen to patients' experiences and act on them to implement improvements. The findings of the study, therefore, will be of use to the Ministry of Health, Provincial and District Health Management Teams and other stakeholders such as Non-Governmental Organizations (NGOs) in organizing, implementing and supervising health care delivery that is responsive to user's needs.

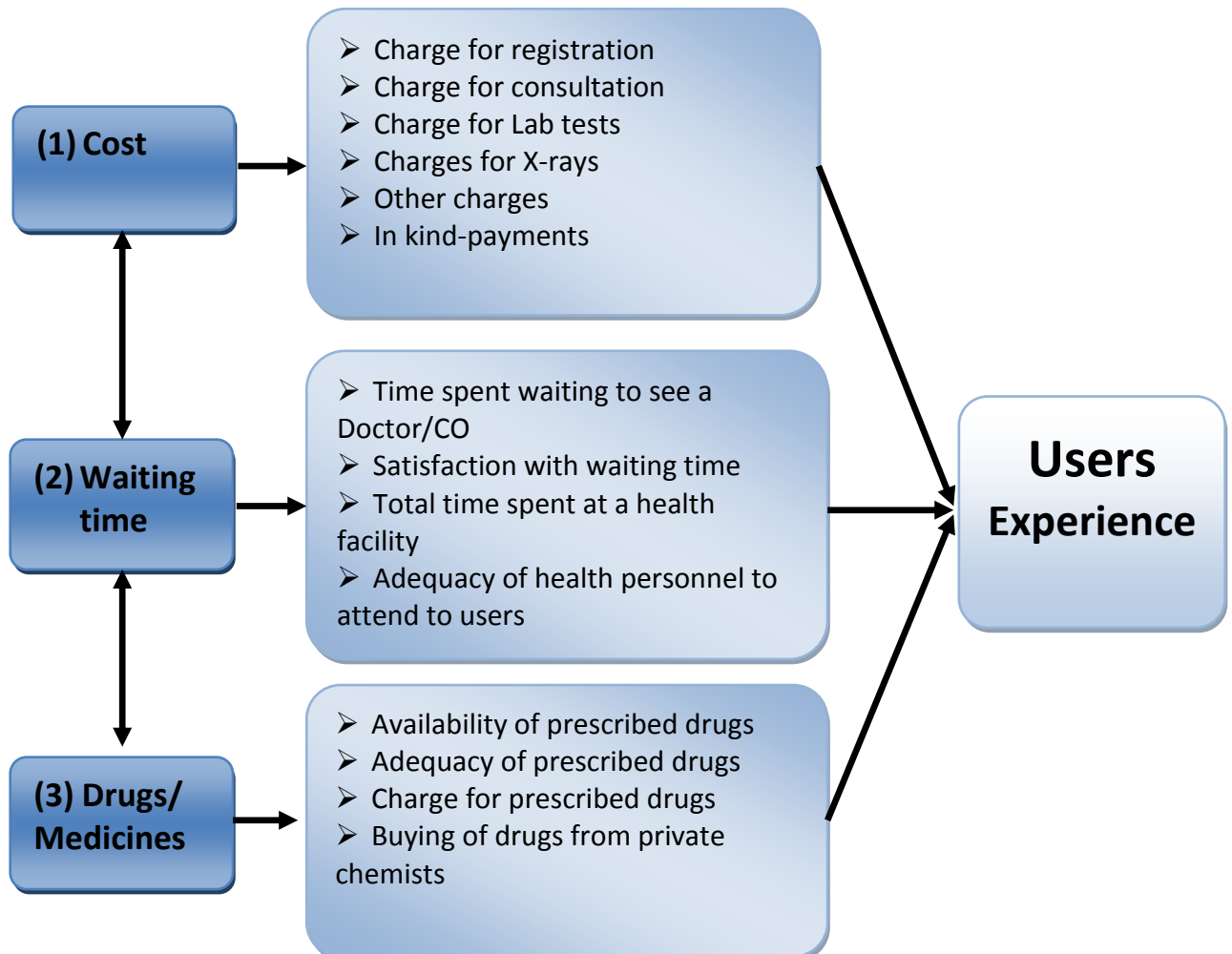
CONCEPTUAL FRAMEWORK

This study used a conceptual model that recognises three key variables that influence a user's experience of healthcare. The three key variables as depicted in the model in **Figure 1** are *Cost*, *Waiting Time* and *drugs/medicines*. Healthcare should not only entail affordability but should also entail an acceptable waiting time and the availability of drugs. The three variables are assumed to be interdependent:

- i) Cost that user's experience includes the charges such as registration, consultation, laboratory and other non financial costs like in kind payments of gloves and injections among others.
- ii) Waiting time includes the time they spend waiting to see a doctor or a clinic officer, the total time they spend at the health centre and the adequacy of personnel to attend to patients.
- iii) Drugs/Medicines: the users will experience drug availability, whether the drugs are adequate, whether the drugs available are paid for and whether they had to buy drugs from private chemists because health centres did not have the drugs

As shown in conceptual model in figure 1.1, the charges for each service show the cost which users encounter and experience at health facilities. The time spent show how long users waited to receive health services. Availability, adequacy and buying of drugs show how users acquire drugs/medicines.

Figure 1.1: Conceptual model of users' Experience of Healthcare Services



A user will have a positive or negative experience based on: i) cost or charges encountered at health facilities are; ii). how long they wait and stay at health centre; and iii) the availability of drugs at the health centre.

In this conceptual framework:

Users: refer to people or patients that used a health facility both in the period prior to the removal of user fees and after their removal.

User fees (charges) refer to the charges paid by users who seek health care including registration fees, consultation fees, admission fees, medical examinations and drug charges encountered at a health facility.

Experiences refer to the past and current events or particular situation(s) of physical, social, psychological or economic happening that a user encounters while at a health facility. It is the feedback from patients on what actually happened in the course of receiving care or treatment. A User's experience should typically begin with an effort to acquire the services at a particular health facility. Upon arrival at the health facility, users undergo registration which is then followed by consultation and diagnosis. Some users may be required to take some tests before they can be given medication. A user may be required to wait to be attended as they undergo all the procedures.

i) Cost means the charges encountered at health centres even after the removal of user fees. Costs may influence a user's interpretation of a positive or negative experience because primary services are to be provided free of charge.

ii) User's waiting time means the time spent by users between arrival at a health facility and the time they are attended to by a health practitioner. The time it takes to receive a service at a health facility influences a users interpretation of a positive or negative healthcare service experience. When users are subjected to long waiting period before being attended to, they are likely to have a negative experience because visiting a health institution is just one aspect of individual's daily routine and programs. The availability of adequate numbers of qualified and experienced health workers, in the right skill-mix, is a major determinant of how long users wait

at a health facility. Further, research has shown that long waits for care can contribute to declines in health status and poorer outcomes of care, and can impact the health care system overall. Long waits have been known to lead to increased worry, anxiety, stress and pain (Canadian Institute of Information, 2012).

iii) Drugs/Medicines refers to the medicines that are prescribed after diagnosis. Availability and access to essential vaccines, drugs and medical supplies are critical factors in ensuring efficient and effective delivery of health services because, after diagnosis, users or patients can only get better if they have access to drugs.

LITERATURE REVIEW

This section focuses on related literature to the study. It presents the existing literature in Zambia, Africa and the world at large where experiences of users after fees removal have been documented. In addition to presentation of literature, the review highlights the importance and contribution of the existing literature to this study, the key limitations of the existing literature and further provides ways in which this study attempts to fill the knowledge gap found in the existing literature on user experiences after the removal of user fees. This section also provides a summary of all literature.

User fees refer to the payment of out-of-pocket charges at the time of use of health care. In this sense, they go beyond concretizing the idea that it is desirable for consumers, regardless of their income, to make contributions to the financing of public health care in addition to those they make through taxes. It prescribes the timing of the contribution relative to the time of needing and receiving health care (Dyna, 2001).

Many low-income countries including Zambia had introduced user fees for publicly provided health services, often as part of structural adjustment programmes. User fees were usually only one element in a broader package of health sector reform measures (Cheelo, et al., 2010). As such, user fees are not a perfect solution to the inadequate funding for the health care sector. They had proven to be ineffective as a stand-alone policy. Zambia experienced a raise in revenue flow from user charges had at the same time experienced drastic reduction in care utilization and no improvement in the quality

of care. User fees, therefore, had an obvious drawback which is their potential negative effect on access to health care. In many cases, partly because of poor implementation, utilization decreased significantly after user fees were raised, affecting the poor in particular (CSO, 2002).

On user fees and user's experience, Siachisa (2009) reported that people had initially accepted the idea of cost sharing in provision of public health services. He further argued that surprisingly, after the introduction of user fees as a cost sharing measure, the majority of the people developed a negative attitude towards user fees. He also found that the reluctance in paying user fees was influenced by five factors which were income, occupation, education, availability of quality services and sensitization. He argued that the most negatively affected were those who earned low incomes. The majority of the people were reluctant to pay for health services due to inadequate or non availability health services and facilities as well as lack of sensitization. Based on the factors identified, Siachisa argued that users resorted to utilising other sources of health including traditional healers, spiritual leaders, private local drug stores, chemists and clinics. The majority users, therefore, felt that user fees should be abolished.

Kunda (2009) reported that there was a significant association between non affordability of the user fees and person responsible for intra-household decision on finances. Almost all the respondents agreed to having been charged user fees. Most users were charged K5 (67.99%) and this charge was also closely related to the non affordability especially among the women respondents. The report also documented that 61.45% reported having been sent away at one time because they could not pay the amount required. Kunda further argued that user fees had a negative impact on women's access to quality health care. Unemployment, low levels of education, amount charged for health services, cultural factors among women were some of the factors he identified as having contributed to women failure to afford care. Kunda also concluded that fees be abolished and that government should to increase funding to the health sector to offset the lost revenues that were generated from user fees.

In a 2007 report by Mubiana, it was found that 65% of the respondents in Senanga District in Zambia were not able to pay user fees. The report showed that cost sharing

had been a barrier to accessing the medical treatment for the respondents. The number who fell with the income category were significant. Conclusively, her investigation revealed that a large number of respondents were finding difficulties in meeting the cost of public health services (Mubiana, 2007).

A review of literature by the CSO, Siachisa, Kunda and Mubiana showed that user fees or charges had one common negative effect of access to healthcare which thereby affecting utilisation and in some cases influencing the health care seeking behaviour.

Because user fees posed a barrier to access of health care services, a general consensus emerged at the international level that user fees should be abolished (Save the Children, 2009, UN General Assembly, 2009). Progressive means of Healthcare financing was encouraged such as taxation or national health insurance mechanisms that do not penalise those who are least able to pay. Zambia is among a few low-income countries including Malawi and Uganda had made primary healthcare free.

Undoubtedly, ser fee abolition, enacted in Zambia, focused on removing one key cost barrier thereby improving access for the poor. The Zambian government provides free primary healthcare services and funding is from the general tax revenue (MoH, 2013), providing healthcare services from the general tax revenue is in line with the 2009 general consensus.

Using a pooled synthetic control method to evaluate the impact of Free primary care in Zambia, Lépine, Lagarde, & Le-Nestour (2015) confirmed that the removal of user fees policy virtually eliminated medical expenditures, thereby providing financial protection to health services users. In their view, it would be interesting to know whether removing these other barriers while maintaining user fees would be more effective than removing fees. They also recognised that user fees were removed for consultation, drugs, laboratory tests and X-rays, nonetheless, these direct medical expenses only represent about half of the total expenses incurred during illness. This shows that drugs bought outside the facility, transport, food and caregiver costs which represent as much as half of the total expenses involved in accessing health care services are still being

experienced by users. In addition, these expenses do not include the opportunity cost of time that has been found to be a main barrier for seeking care in rural settings.

Although Lépine, Lagarde, & Le-Nestour (2015) who argued that provided vital information on the financial effects on users health expenses at health facilities after the removal of user fees, it was a study based synthetic control construct. Therefore, there was no direct attempt to find out from the actual users on their experience of healthcare and this study bridged the gap.

Contrary to Lépine, Lagarde, & Le-Nestour who argued that the removal of user fees policy virtually eliminated medical expenditures, thereby providing financial protection to health services users, Chama-Chiliba (2014) argued that removing user fees had led to cost shifting, resulting in additional costs for pregnant women, thereby contributing to the use of informal care rather than facility-based deliveries. Moreover, with the abolition of fees, women were required to provide their own supplies bleach, gloves, and syringes to be used when delivering at a health facility. Extra costs for women following the removal of user fees serve as additional barriers to the use of delivery services. Chama-Chaliba concluded that to reduce maternal deaths in Zambia, there was need to focus attention on other important barriers that prevent facility deliveries, including distance and travel costs.

Chilima-Chama provides information on the importance of flexible financing that was drawn from user fee and enhanced the effectiveness of health care delivery. He shows that in-kind payments increased after the removal of user fees were users are required to provide their own supplies. However, his emphasis was on rural areas and the study focused on facility-based-deliveries and as such, this study will focus on the urban areas to ascertain whether users of urban health centres also experienced in-kind charges after fees removal and strictly focus on primary service.

In relation to charges and quality of care at health centres, From a national survey of 2014 (N = 59 500 respondents) which focused on the determinants of utilisation of outpatient health services in Zambia, Masiye and Kaonga (2016) found that a total of 80% of patients who visited public primary healthcare facilities on an outpatient basis

reported not having incurred any medical, travel or any other healthcare-related out-of-pocket expenses [Masiye and kaonga (2016), Masiye Kaonga, Kirigi (2016)].

Masiye and kaonga's findings revealed that the implementation of user fee removal policy had been routinized in the Zambian public health system. Despite the removal of user fees on public primary healthcare in Zambia, access to healthcare was highly dependent on an individual's socio-economic status, illness type and region of residence. They argued that households with very limited financial means or none at all, were unlikely to seek care because of the perceived or real financial commitment that comes with formal healthcare utilisation. Furthermore, Masiye and Kaonga suggested that the benefits of the policy of free primary healthcare in the public sector disproportionately accrue to the users of Health Centres that resides in more urbanised areas with generally better physical access to better-resourced health facilities.

However, the report by Masiye and Kaonga does not explicitly report on the 20% that may have encountered charges since only 80% of patients who visited public primary healthcare facilities reported not having incurred any medical. Therefore, there was a gap in literature on whether charges were on primary health care services and on what services the patients or users were charged. This study aimed to bridge the gap on the kind of charges that users encountered on primary healthcare services.

Masiye et al (2008) found that most patients believed that quality had remained almost the same since the removal of user fees policy was put in place. Nearly a third of the respondents reported that the total cost of seeking care had dropped, but, one tenth said that the removal of user fees had not reduced their cost of seeking care. None of the respondents reported that they had paid any money to anyone at the facility for any service. These services included registration, consultation, drugs and medical examination. The study also found that neither staff courtesy nor the quality of the consultation had deteriorated after the removal of fees. With regard to waiting times, patients in rural areas were unable to give an accurate estimate of how much time they spent waiting at a facility. Users in rural areas were unable to report the time spent at a health facility. Further, the study found that nearly 20% of patients stated that drug availability had worsened and this was because patients were simply given a prescription

and told to buy the prescribed drugs elsewhere because not all types of medication were available at the health centre.

The paper by Masiye et al is important to this study because it concentrated on utilisation and quality after the removal of user fees. In their report, they concluded that patients only encountered costs with regard to money spent to buy one's own drugs after diagnosis because the health facility did not have supplies of all the drugs. The study also showed that the removal of user fees had little impact on overall provision of health care, especially in terms of staff courtesy as there was no evidence to suggest otherwise.

However, Masiye et al relied on facility based data. Much of the information that their study collected was based on information provided at the health facility. Although they captured perceptions of users, they did not capture the actual salient experiences of users. Instead of allowing users to express their experience of waiting time, they observed users and determined the time users spent. Further, their report was also based on the perceptions in rural areas, thus, it was important to find out the experiences of users in urban areas. Perception does not measure the actual, it is what people think and not what is happening. Instead of measuring what people think, this study documented the actual experiences that users had. Finally, this study focused on urban health centres as opposed to rural health centres where most studies on removal of user fees were previously conducted. Urban health centres may have fewer human resource deficits as many health workers prefer to work in urban areas. According to the MoH (2011), it is estimated that rural areas have seventy 70 clinical Health Workers per 100,000 population relative to 159 per 100,000 in urban areas. Therefore, the study on user experiences in urban areas was necessary.

Hadley (2011) focused on the understanding utilisation of health facilities in the context of the fee removal policy with particular emphasis on local practices. She found that the success of the removal of user fee policy was typically measured in terms of increase in utilisation. Hadley also found that even after the removal of user fees, users were denied healthcare due to distance, staff attitudes, waiting time and additional costs. She also found that users were frivolously using and sharing medicines in the community. The conclusions of Hadley were important to this research because it provided an insight into

the local healthcare practices in areas where fees were removed and in other areas where fees were still being charged.

However, like many previous studies conducted in Zambia, Hadley mainly focused on rural areas where the removal of user fees policy was first implemented. She also focused on increase in utilisation which does not reflect the actual experiences of the users. Increase in utilisation in itself does not depict the actual service received and of what quality. This study did not only focus on utilisation, but it also captured the actual experiences of users in terms of the times they waited as utilisation had increased.

In relation to drugs, evidence on the removal of user fees in rural and peri-urban areas had shown that this policy shift resulted in increased utilisation of health services, although the policy was undermined by the impact of the shortages of drugs and human resources. However, this pro-poor policy shift has not benefited the urban poor, who still need to pay fees before accessing health services (MoH, 2011).

In the 2011 to 2015 health strategic plan, the MoH recognised increased utilisation after the removal of the user fees in rural and peri-urban areas had impacted on availability of drugs and adequacy of human resources. It was therefore cardinal for this to establish whether drug availability and adequacy of personnel were addressed as the removal of user fees policy was extended to Urban Health Centres.

Onde (2009) in a report titled “Impact of abolishment of user fees in rural health centres”, found that drug availability was fluctuating before and after the removal of user fees in the nine health centres that were being assessed. He concluded that on average, drug availability declined from 90 percent in 2004 to 84 percent in 2005 before user fee removal and then increased to 85 percent in 2006, 88 percent in 2007 and then dropped to 75 percent in 2008. This means that drugs stocks before the removal of user fees were better overall as compared to after the removal of user fees. According to Onde, the general understanding through interviews with the health centre staff and users was that the quality of service after the removal of user fees was not as good as before. Onde cited the low morale of health workers, increased workload affecting the performance of health workers, loss of community ownership of health centres, reduced

numbers of casual workers that were previously paid from user fees and reduced availability of drugs.

Onde's findings were indispensable to this research because they focused on the experiences of the users both before and after the removal of user fees. Because the study provided information of pre and post policy implementation, it enhanced the effective comparison and interpretation of the impact of the policy such as a better drug availability of drugs prior to the removal of user fee policy. The study also revealed that users lost a sense of ownership of health centres because the health facilities were now solely dependent on government funding.

However, Onde seems to provide contradictory views when he reports on the availability of drugs. He reported that drugs were better in the periods after the removal of user fees but also cites the reduction of drugs as a negative impact of the removal of user fees. Additionally, Onde's study mainly focused on utilisation of health centres after the fee removal. Despite dealing with quality of services, Onde was making a comparison between quality before and after the removal of user fees. His focus on funding, utilisation, quality and revenue collected from user fees broadened his study. Therefore, Onde's report did not adequately include the unique experiences of the users which this research endeavoured to undertake to fill the knowledge gap.

Still on drugs, Nabyonga-Orem, J et al (2008) reported that half of public health facility catchment areas patients did not get the prescribed drugs because they are not available in Uganda. Twenty three percent (23%) of Health Unit Management Committee members (HUMCs) reported there were inadequate stocks of drugs although improvements in drug availability were noted in some years. When drugs were not provided at the health unit, the users reported employing a variety of coping mechanisms. The most commonly reported coping strategy was to visit private clinics or buy drugs from drug shops.

But Nabyonga-Orem, J and others did not actually specify in frequency or percentage the experiences of users. They merely presented information in terms of speculations.

On the contrary, this study provides both the frequency and percentages of the people that received or did not receive drugs at the health centres.

With regard to waiting time, Tufton and Waller (2013) in an investigation about the effect of the no-user-fee policy on health services in Jamaica revealed that two thirds (68.4 percent) of the respondents had spent more time waiting to see a doctor. Though two thirds waited longer to see a doctor, Tufton and Waller found that the majority (65.5 percent) of the respondents expressed the view that time spent with a doctor had not been affected by the abolition of user fees. Furthermore, the paper by Tufton and Waller revealed that respondents supported the re-introduction of user fees on the grounds that free health care was not sustainable. Those who support the re-introduction of user fees were of the view that the Jamaican health care system has gotten worse since the abolition of user fees.

Additionally, Tufton and Waller reported that service delivery to users was ineffective and inefficient with nurses and doctors displaying an apathetic attitude towards patients and their general duties. From the experiences of users, Tufton and Waller concluded that service delivery had not only gotten progressively worse but also exceedingly slow. According to Tufton and Waller's, users felt that better quality and faster service would be given if fees were paid. Overall, Tufton and Waller's study revealed that the introduction of no-user-fees strategy had the greatest impact on pharmaceutical supplies, followed by staff; medical supplies; waiting time; space; service delivery and processing of patients.

Although the study by Tufton and Waller was extensive, it merely focused on the general efficiency and inefficiencies of health facilities after the no-user-fee policy. Their paper also combined both the experiences of users and health providers. Because this report was wide covering a myriad of variables, it was not elaborate as to express the real user experiences. As such, this study endeavoured to determine the views of people in urban areas of Mtendere and Chelstone townships in a more specific manner by determining the effects of the removal of user fee policy on specific variables including cleanliness of health facilities, respectfulness and privacy of health practitioners and the overall courtesy given to users after the removal of user fees.

Morestin and Ridde (2009) synthesised a policy brief on “The abolition of user fees for health services in Africa”. Their objective was to consider some possible answers to questions of abolishing user fees by synthesizing what the published scientific studies on experiments with fees abolition in Africa. The policy brief showed that Primary care curative visits had increased between the periods before and after fees abolition: from 17 percent in Madagascar, up to 84 percent in Uganda. However, unexpected trends emerged elsewhere, such as in Uganda, where the utilization to private health care services was on the rise. The newly introduced free services created more demand which the public sector could not accommodate. This made some patients to turn to the private sector. Further, the policy brief also found that despite the abolition of user fees, patients continued to pay certain expenses. It was found that when public-sector resources are insufficient (especially medicines), those who are able to pay turn to private services. Some costs such as the transportation to health facilities were not covered by the abolition policies. Some users incurred some financial costs due to unofficial payments.

Morestin and Ridde concluded that the abolition of user fees did not solve all problems related to health care costs. They also noted dissatisfactions from the health care workers who suffered the consequences of a lack of planning. Inefficiency in the policy implementation resulted into stressful relationships with unhappy patients whenever fees abolition was suspended or not effective such as lack of drugs. Overall, abolition of fees had achieved its main objective of utilization of services (especially primary care visits and assisted deliveries) particularly among the poor. The people appreciated the abolition of fees.

Morestin and Ridde’s findings were significant to this research because they provided information from different countries on user experiences after the removal of user fees. Their report is vital because it showed the varying user experiences in different countries, including user satisfaction, quality of service, availability of drugs and continued user charges and costs to access the purported free health care. However, because they relied heavily on secondary data, they did not provide a comprehensive view on the actual revealing situation in the six countries they reviewed. In countries such as Ghana and Senegal, their knowledge was very indirect because they mainly

reported what they had read. Questions can also be raised on the reliability of their findings. Their conclusions were based largely on retrospective analysis. But, key informants may have forgotten some actions that took place. For these reasons, this research aimed to investigate and fill the knowledge gap that existed of users experiences by utilisation primary data collection methods that took the research to the actual users that experienced the service. Further, this study focused on the users' experiences as opposed to workers' experiences.

Meessen, et al., (2009) conducted a multi-country review on removing user fees in the health sector in Low-Income countries. The main objective of the multi-country review was to draw lessons (do's and don'ts) that could guide the future formulation and implementation of such policies in other countries. Their review also focused on the 'how', once a government has decided to abolish user fees. More in particular, the study documented the processes and strategies through which user fee removal reforms had been implemented in six sub-Saharan African countries: Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda. It was, therefore, mainly a descriptive study. Yet, it was informative on what is going on in sub-Saharan Africa in terms of removal of user fees.

The multi-country review showed many barriers faced by users, especially the cost of transport remained. More thorough analysis showed that in some countries, the higher utilization was more marked in certain population groups such as individuals living close to the health facilities. Therefore, the review concluded that removing user fees did not lift all financial costs for the households. In Uganda in particular, the study revealed mixed results. This was attributed to the fact that drug shortages were recurrent in public health services. Such a scenario obliged households to buy their drugs in the private pharmacies. Apart from this, the household surveys in Uganda confirmed the increase in the utilisation of public services (in total and by the poor), but they also showed a major increase in the utilisation of private services, possibly to address the limitation of public services, especially drug shortages. In Madagascar, utilization doubled in 1997-8 after introduction of user fees, but then decreased sharply in 2000 during a period of political turmoil. Subsequent elimination of fees was associated with a 21% increase in utilisation. Upon closer examination of data, however, part of the reason for the initial

increase in utilization was that many patients were returning two or three times for the same illness because they are not being fully treated due to the lack of drugs or supplies during their first visit. Consequently, fees were re-introduced in 2003, mainly because alternative financing mechanisms were not adequate, resulting in drug shortages emerging.

However, because the study by Meessen et al was broad, focusing on several aspects of the removal of user fees, it did not capture the extent to which healthcare users experienced variables of healthcare. Other than drug availability, courtesy to users, availability of reagents and availability of human resources are variables that enable effective healthcare delivery. A study that focused beyond drug availability to include costs and waiting time was, therefore, imperative.

On the other hand, Chuma, et al, (2009) conducted a study on reducing user fees for primary health care in Kenya (Makueni and Kwale districts): Policy on paper or policy in practice. In their report, facility-level data showed that reported levels of charges differed between and within districts, with very few facilities reporting strict adherence to the 10/20 policy. Adherence to the 10/20 policy referred to a situation where dispensaries and health centers charged registration fees of KES 10 and KES 20 respectively, with children under the age of five and some illness conditions (such as malaria and tuberculosis) being exempted from paying the registration fees. Any extra charges (such as laboratory fees, cards, drugs, delivery) indicate non-adherence to the policy. Facilities were classified as adherent/non-adherent to the policy based on reports on these charges from health workers interviews. The findings by Chuma et al (2009) indicated levels of reported adherence, which were different from verified adherence.

Facilities in Makueni were more likely to adhere to the 10/20 policy than those in Kwale. Only four facilities in Kwale adhered to the policy compared to ten in Makueni. Facilities charged for different kinds of services including: registration, injections, drugs, deliveries and laboratory services. Results from exit interviews supported findings from health worker interviews. About 57 percent of exit interview participants in Kwale and 20 percent in Makueni who reported being charged for treatment on the date of the interview paid more than the recommended charges under the 10/20 policy. Median

levels in Makueni reflected the recommended charges under the 10/20 policy, while median charges in Kwale were double the official amount. Communities had very limited understanding of the 10/20 policy. Approximately one third of survey respondents could not correctly state the recommended charges for dispensaries, and half did not know the recommended charges for health centres. Community members were more concerned about having to pay for registration than for drugs, particularly given frequently reported drug shortages. Many asked for greater clarity and communication from authorities regarding charging levels. The study by Chuma et al provides information of user experiences with regard to charges after fees were reduced. Although the study by Chuma et al was important to this study, their study only focused on reduced charges. There is need to find out whether users are charged for services when the fees are completely removed for some services. This study filled that knowledge gap.

In Jamaica, Campbell (2013) documented respondent's views on "The Abolition of User Fees in the Jamaican Public Health System". His findings revealed that respondents' rating of the quality of care they had received since the policy change was largely positive. Of the 200 respondents, eighty-nine (44.7 percent) rated the quality of care as good, while 46 (23.1 percent) rated it as excellent, and 64 (32.1 percent) rated it as fair or poor. With regard to time taken to obtain care at the health facilities, respondents reported that waiting time ranged from nine minutes to 12 hours. 85.0 percent of the respondents reported having to wait for between 1-6 hours. Of these, 54.0 percent waited between 1-3 hours, while 31.0 percent waited for up to 6 hours for care. This represented a mean waiting time of 3.1 hours. Generally, respondents travelled between 0.25 and 40 miles to the nearest health facility. Seventy eight percent of the respondents travelled between 0-5 miles to the nearest health facility of their choice.

Furthermore, Campbell's ascertained respondents' knowledge regarding free health care'. He concluded that most respondents (98.9%) were aware of the free health care but only a few (7.5%) were aware of all the services that could be accessed freely. Sixteen percent of the respondents were able to identify four free services, while 32.5

percent identified three free services. Twenty six per cent identified two free services and 6.0 percent were aware that only some drugs could be accessed free.

In reflecting on their observations since the abolition of user fees, respondents reported that they had observed more people using the health system 82.0 percent, free health care helping those who could not afford it 20.0 percent, good service 12.5 percent, poor service 11.0 percent, and positive staff attitudes 1.0 percent. Cost-related problems encountered while accessing care were mainly 51.5 percent inability relating to the purchase of prescribed drugs. Thirty-one per cent could not afford transportation but 35.5 percent reported having no problem in obtaining drugs.

Campbell's conclusions are key to this research because the information provided on users experiences included the distance to a health facility, time taken to be attended to by the health practitioners, cost of accessing the health service and basic knowledge of the free services. The report also revealed experiences on the availability of drugs at health facilities. It can thus be said that users experienced costs of transportation and acquisition of drugs after the removal of users fees because the increase in utilization resulted in the more demand without an adequate supply. However, Campbell did not focus on a facility which was nearest to the respondents' home. As such, although his report provided vital information, it included information that is not affected by the abolition of user fees such as transport costs. Whether there are fees or when fees are removed, users will still experience transportation costs. His view that users were able to afford drug costs and not transport cost was questionable. Users may not access services if they are unable to pay transportation costs. In most cases, drugs are more costly than transportation to a health facility. Therefore, this study focused only on the variables that are directly affected by the removal of user fees and not important aspects that are insignificantly affected by the policy change. The study also focused on health facilities that are in the users catchment area.

Summary of Reviewed Literature

User fees policies were found to have positive, negative and mixed impacts on utilisation of health services. Experience has shown that abolition of user fees in developing countries served as a catalyst for increased utilisation. Further, most users

showed awareness of the removal of user fees and experienced increased user utilisation of health facilities. The literature also shows variations in the experiences in relation to the level of education attained, income earned and area where the information was documented.

With regard to access and user charges, the main barrier to access of health care services was user charges before it was removed. The abolition of fees had achieved its main objective of increased utilization of services particularly among the poor. Most people appreciated the abolition of fees. Nevertheless, the literature reviewed also showed that removing user fees did not lift all financial costs for the households. Although most of the respondents reported that they did not pay any money to anyone at the facility for any service, some respondents were charged for some services even after fees were removed. Respondents also experienced increased waiting time and health related costs such as transportation or buying of medication. Some users experienced a shift in charges from financial to in-kind payments.

However, there were gaps in literature on access and charges encountered. Some gaps were related to the sources of data of users experience. Most reviewed literature was from rural areas where the policy was first implemented in 2006. Further, some scholars reported of charges even after the removal of user fees but did not explicitly mention the charges that users encountered. This study focused on the urban areas to ascertain whether users of urban health centres also experienced in-kind charges after fees removal and strictly focus on primary service and describes any charges encountered if any.

On drug availability and waiting time, generally, most users experienced lack of drugs and inadequate health personnel due to increased utilisation. In addition, some studies showed that health services became progressively slow, and there was a stressful relation between users and the care providers because the health services had deteriorated. Because of deteriorated health care services at public health institutions, literature has revealed that some users resorted to private health institutions as the alternative.

However, literature on availability of drugs is marred with inconsistencies and relied on facility based data in some cases. Further, some gaps identified were on the measure of effect of removal policy, increase in utilisation alone cannot entail nor reflect the actual experiences of the users. Scholars did not properly document the experiences of users especially in cases where contradictory information is provided. Based on the gaps in literature such as the reliance on secondary data which does not provide a comprehensive view on the actual revealing situation, this study aimed to bridge the gap by focusing on the beneficiaries of free healthcare.

METHODOLOGY

This section presents the methodology used to answer the research objectives. It commences with an overview of the study designs used. It then provides information on the study site and sampling. The methodology also provides information including instruments, techniques of data collection, data analysis, and how reliability and validity were achieved. Ethical concerns were also captured in the methodology.

Research Design

The study used a descriptive survey research design. This design was used to accurately document the unique experiences of users' of urban areas after the removal of user fees was extended to all primary healthcare facilities in 2012. Most studies conducted on the removal of user fees were in rural areas where the removal of user fees policy was first implemented in 2006. This design used both qualitative and quantitative approaches.

Study site

The study was conducted in the Lusaka district of the Republic of Zambia. The study was largely a household survey conducted in Mtendere and Chelstone residential areas in Munali Constituency of Lusaka District. The study participants were selected from the Mtendere and Chelstone households who were users of the health centres of the two sample areas. A high density area (Mtendere) and a medium density area (Chelstone) were selected in order to provide a comparative analysis of experiences and levels of effectiveness on healthcare delivery of the areas.

Sampling

Two sources of data were used: a) a survey of households in two study areas and b) interview of the key informants.

In the first case, the study consisted of a sample size of 260 household respondents divided proportionately (130 each) using the catchment populations of the health centres under study namely Chelstone and Mtendere. The sampling frame was data on Standard enumeration Area (SEA) of Munali Constituency from the Central Statistics Office (CSO). Since wards are demarcated into Census Supervisory Area (CSAs), which are in turn demarcated into SEAs, the household sample was selected using a sample frame of the SEAs within the catchment areas of Chelstone and Mtendere Health Centres.

The study used a two-stage stratified cluster sample design. An Enumeration Area is a convenient geographical area with an average size of 130 households or 600 people. In the first stage, 20 SEAs (10 from the Chelstone cluster and 10 from the Mtendere cluster) were randomly selected. In the second stage, 13 households were selected from each SEA. Using systematic random sampling, an interval of 10 was used to select households in each SEA. Therefore, every 10th household was sampled/ enumerated from each sampled SEA. Within each household, the head of the households or any other member of that family that utilised their respective health Centre in the period being studied was interviewed using a semi-structured questionnaire. (Using the statistical package for social sciences (SPSS) to filter respondents, only responses from respondents that had previously utilised the services of Chelstone and Mtendere Clinics in the period 2012-2014 were analysed).

In the second case, the study included Fourteen (14) key informants. Of the 14 key informants, two (02) were district community health officials and twelve (12) were health workers (six (06) from Chelstone Health Center and six (06) from Mtendere Health Center. The six health workers from each health center consisted of one (01) management official, one (01) Doctor/Clinic Officers, one (01) Pharmacist, two (02) Nurses and one (01) administrative staff. The key informants were selected using purposive sampling in order to collect vital information. Therefore, participants were

selected based on their professional levels in terms of job classification, as well as level of involvement in the health system, for example, those with administrative responsibility (In-charge) or those working in the pharmacy (pharmacist).

Data Collection

Both Primary and secondary data were collected. From the 29th of May 2015 to the 3rd of July 2015, primary data from households and health facilities was collected using interviews. Questionnaires containing both close ended and open ended questions were used to collect data from households from Chelstone and Mtendere townships. An interview guide was used to collect data from the key informants. Both the questionnaire and interview guide were semi structured to ensure consistency. Because the questionnaire and interview guide consisted of open and close ended questions, both qualitative and quantitative data was collected. Generally, mixed methods of quantitative and qualitative data was adopted to enrich the study and to enhance the robustness of the findings.

On the other hand, secondary data was collected using documented research from the Ministry of health (MoH), Lusaka District Community Health Office (LDCHO), Chelstone Health Centre, Mtendere Health centre, the internet, University of Zambia library and other relevant data sources.

Data Analysis

For the quantitative data, the study used two statistical software for analysis. The data was first entered and cleaned in Statistical Package for Social Sciences (SPSS) version 16 software. Preliminary analysis was also done in SPSS. Nevertheless, the data was exported to Stata version 11 where univariate and bivariate analysis was done to present descriptive statistics. The SPSS and Stata outputs were thus exported to Microsoft office Excel spread sheet to generate standard tables and graphs. On the other hand, qualitative data was transcribed and analysed using NVIVO software. The transcriptions were thus organised and grouped into major themes.

Ethical consideration

The study was approved by the Humanities and Social Sciences Research Ethics Committee (HSSREC). Permission to use the data for this study was sought from the Ministry of Health and Ministry of community Development, Mother and Child Health. The study posed minimum risk to study participants because no name or personal details were included in the study.

STRUCTURE OF DISSERTATION

This Dissertation is divided into six (6) chapters. Chapter One includes the background of the study, the statement of the problem, the study objectives, the rationale of the study, Literature Review and Methodology. The chapter expands each of inclusions into its subdivisions. Chapter Two is the Demographic and Socio-Economic Profile and Overview of Health care delivery System of Lusaka City. Chapter Three focuses on users' experience of affordability of healthcare services after the user fees removal. Chapter four documents users' experience with timely and adequacy of health personnel after the removal of user fees. Chapter five details the users' experience of availability of drugs after the removal of user fees. Chapter Six is a presentation of conclusions and recommendations.

CHAPTER TWO

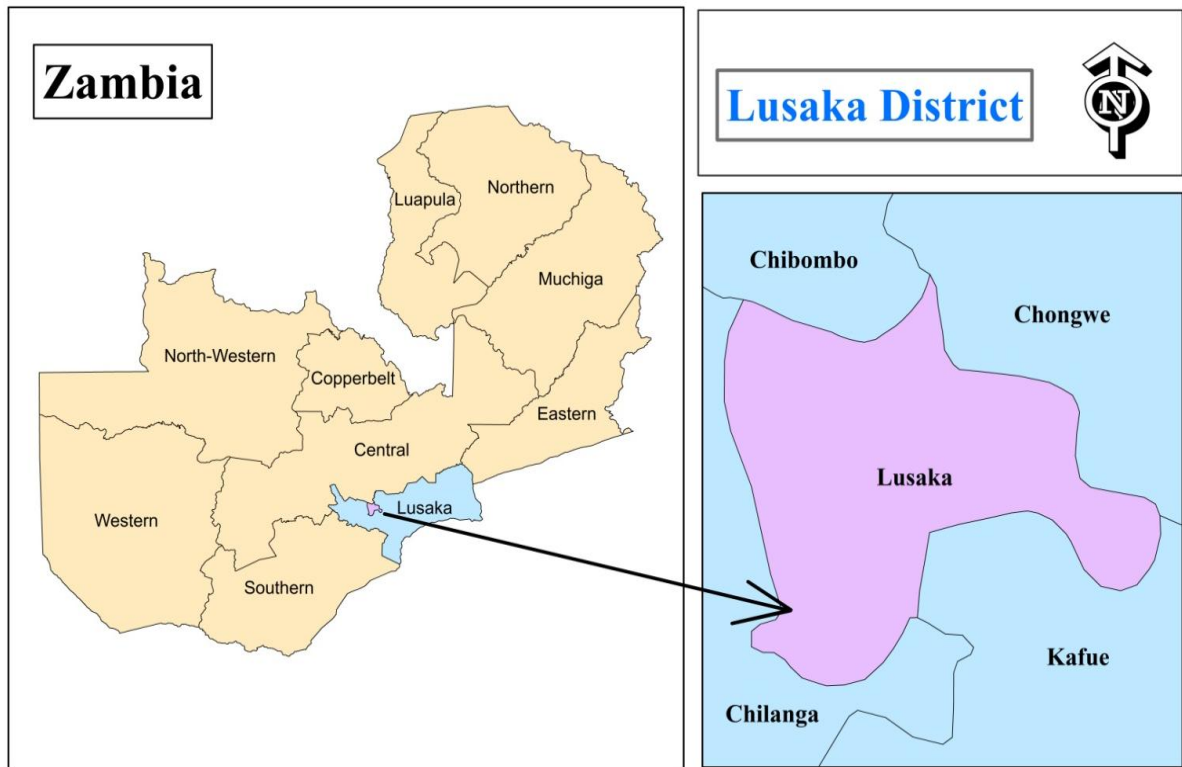
PROFILE OF THE DEMOGRAPHIC, SOCIO-ECONOMIC STATUS AND THE HEALTHCARE DELIVERY SYSTEM OF LUSAKA DISTRICT

INTRODUCTION

The health of individuals and communities is usually determined by the environment and circumstance in which they live and operate. These include the social and economic environment, the physical environment and the person's individual characteristics, behaviour and circumstances. This chapter captures the demographic and Socio-Economic characteristics of Lusaka districts. Important characteristics such as population size, education, health and economic status have been presented. The chapter also focuses on an overview of the Health delivery system as it purports to provide information on how the healthcare is delivered.

PROFILE OF THE DEMOGRAPHIC, SOCIAL AND ECONOMIC STATUS OF LUSAKA CITY

Figure 2.1. Map of Lusaka District



Source: Author, 2016

Demography

Lusaka district is the most urbanised district in Lusaka province. In the 2010 census, there were 1, 747, 152 people living in Lusaka district, all of whom constitute the urban population because the district does not have a rural population. The number of households in Lusaka stood at 358,871. There are slightly more females than males in the city. That is 860,424 (49.2% were male and 886,728 (50.8 %) were female (Central Statistical Office, 2012).

Lusaka city has seven (07) constituencies and Thirty (30) Wards. The constituencies are Chawama, Kabwata, Kanyama, Lusaka Central, Mandevu, Matero and Munali Constituency. Of focus is Munali Constituency which had 261,975 people with 53,927 household (Central Statistical Office, 2012). The city is divided into three residential categories; low density areas, medium density areas and high density areas. Low density areas (Suburbs), include Handsworth Park, Kabulonga, Meanwood (Ndeke Village), Woodlands among others. Medium density areas include Kalundu, Chelstone, Chainama Hills, State Lodge, Chalala, Chilenje to mention but a few. However, most of the population is in high density areas (slums or unplanned compounds). These include Mtendendere, Kalingalinga, Bauleni, Kaunda Square (stage one and stage two), Chilanga and Chainda among others (Lusaka city council, 2013).

Economy

Lusaka's central location, in addition to its capital city status, gives it strategic importance, as it is easily accessible from all parts of the country. The economy of Lusaka has become more diversified with its physical expansion and population growth. Lusaka also plays a significant role in the country's manufacturing. Food processing enterprises, such as milling, meat processing and production of essential commodities such as detergents and other domestic chemical products seem to be concentrated in Lusaka (Central Statistics Office, 2014). Poverty continues to affect a number of households in Lusaka with an estimated 24.4% of the population classified as poor (Central Statistical Office, 2012b). In terms of employment, the service sector is the largest employer of the city's labour force. Nevertheless, Lusaka district had the highest

unemployment rate in Lusaka Province in the 2010 census which stood at 20.8 percent (Central Statistics Office, 2014).

Health

According to the Lusaka District Health Management Team (2015), the city has about six (6) first level public hospitals. These are Chainama Hill Hospital, Cancer Hospital, University Teaching Hospital, Levy Mwanawasa General Hospital, Maina Soko Military Hospital, and Arakan Barracks Hospital. There are also thirty (30) public clinics which include Chainda, Mtendere, Chelstone, and Kamwala Clinic among others. The city has about eight (8) health posts. Further, the city has about one hundred and sixty (160) private health facilities (hospitals and clinics). These include Lusaka Trust, MKP, and Hiltop Hospital. According to the Lusaka District Health Management Team (2015), Lusaka City experiences a number of preventable and treatable diseases. The major causes of death are usually tuberculosis, neonatal prematurity, diarrhoea, anemia, malaria and pneumonia. Lusaka city has an HIV/AIDS prevalence of 22.4% compared to the national prevalence rate of 16%. In 2014, the top three prevalent diseases in Lusaka were Respiratory Infections, Diarrhoea and Trauma (injuries, wounds) (Lusaka District Community Health Office, 2014).

Education

According to the Central Statistical Office (2012), the literacy rate for persons aged five (5) years and older in Lusaka stands at 85.1 percent. Lusaka has ninety eight (98) registered government run primary schools, twenty five (25) basic and secondary schools. Some of the secondary schools include Secondary schools include Munali Boys Secondary School, Kabulonga Girls Secondary School, David Kaunda Technical High School and Libala Secondary School among others. The city also has two hundred and forty (240) community schools. (Ministry of Education, 2013).

In addition, Lusaka has over 150 private schools (Ministry of Education, 2013). But, schools in Lusaka district are poorly distributed. Most of them are located in suburbs whiles there is a shortage in high density areas. The ministry of education vocation and

early child education argues that one of the contributing factors to this poor distribution is the lack of land for constructing new schools in high density areas (Ministry of Education, 2013). At tertiary level, Lusaka is home to about seven (7) universities including the University of Zambia, Cavendish University Zambia, Zambia Open University, University of Lusaka, Lusaka Apex Medical University, Zambia Catholic University and DMI - St. Eugene University. Colleges include The National institute for Public Administration (NIPA), Natural Resources Development College (NRDC) and Evelyn Hone College among many others. There are also a number of trade and vocational institutions offering computer and other related courses (Ministry of Education, 2013).

DESCRIPTION OF THE HEALTHCARE DELIVERY SYSTEM IN LUSAKA DISTRICT

There are different levels of health care systems in Lusaka. Although health services are provided by different institutions, including government institutions, church institutions, mining and other companies, the National Health Strategic Plan (NHSP) 2006-2010 provides a framework within which both the public and private service delivery is organised (MoH, 2011). This framework is based on the Zambia Basic health care Package (CBoH et al 2003). The package is delivered through a system which comprises core health service delivery facilities that fall into five categories, namely: Health Posts (HPs) and Health Centres (HCs) at community level; Level 1 hospitals at district level; Level 2 general hospitals at provincial level; and Level 3 tertiary hospitals at national level. In other words, the hospitals are divided into primary (district), secondary (provincial), and tertiary (central) facilities. Thus, Zambia like many other countries, has a tiered health care structure that facilitates a referral system with complicated cases, moving from primary, secondary to tertiary level (MOH, 2013).

Third Level Hospitals: Third level hospitals which are also called specialist or tertiary hospitals are the highest referral hospitals in Lusaka and Zambia as a whole. Such hospitals cater for a catchment population of 800, 000 users and above. All complicated cases not attended to at second level hospitals are referred to the third level hospital.

Currently, Lusaka district has two (2) third level hospitals and these are: one government hospital, the University Teaching Hospital and one private third level hospital, MKP TMS (MoH, 2013).

Second Level Hospitals: Second level hospitals which are also referred to as provincial or general hospitals are found at the provincial level. They are intended to cater for a catchment population of between 200, 000 and 800, 000. These hospitals also act referrals for first level institutions. Like many districts, Lusaka district only has one second level hospital, the Levy Mwanawasa Hospital.

First Level Hospitals: The third largest level of health care after second and third level hospitals is the first level hospital which is also referred to as the district hospital and has a catchment population to serve of between 80, 000 and 200, 000 users. There are seven first level hospitals in Lusaka district and these are: Maina Soko, Arakan Camp, Chainama Hills hospital, Cancer disease hospital, Hill Top, St. Johns Medical Center Ltd and Trust Medical Services.

Health Centers and Health Posts: There are two types of health centers in the health care delivery system in Zambia. There are urban centers that serve a catchment population of between 30,000 and 50, 000 users and rural health centers that serve a catchment area of 10, 000 users. In Lusaka district, there are 170 Urban Health centers inclusive of Chelstone and Mtendere health centers. However, because Lusaka district has got no rural population, effectively, there is no rural health center. Health Posts are at the lowest level of the health care delivery system. They are built in communities and cater for a catchment population of approximately 3, 500 in rural areas and between 1000 and 7, 000 in urban settings. They are set up within a 5km radius for sparsely populated. In Lusaka, there are currently 11 health posts (MoH, 2013).

CHELSTONE HEALTH CENTRE

Location and Catchment Population

Chelstone is a sub-district health centre that is headed by a medical officer. It falls in district one of the Lusaka district health facilities and is situated on the east of Lusaka 16 kilometres from Lusaka town. It is located in Baobab Street off Palm Drive road on the left side of the Police station. The clinic catchment boundaries is the hybrid turn off, the Great East Road up to the Airport Turn Off. It also covers part of the Galaunia Farm community up to Kapwelyomba Basic School. The health Centre offers healthcare services to a catchment population of 112, 965 users (MoH, 2013). Specifically, the catchment population comprises users from Kamanga compound, Kamanga Overspill 1 to 4, Foxdale 1 and 2, Ester compound, Chelstone police camp, Chelstone extension, Chelstone compound, former Zambia Airways, Roads camp and Nkoloma Area. The newest zone that has been added to the Chelstone clinics' catchment area is Obama Residential Area.

Human Resources at Chelstone Health Centre: Chelstone clinic has a total of 149 staff. The clinic has three (03) medical doctors and ten (10) clinical officers. It has one (01) nursing officer, three (03) registered midwives, nine (09) enrolled midwives, 18 registered nurses and 26 enrolled nurses. The clinic also has three (03) dental therapists, two (02) physio-therapists and two (02) nutritionists. It also has three (03) environmental health technologists, three (03) laboratory technologists and the six (06) Pharmacy technologists. The clinic has two (02) human resource officers, four (04) radiographers, eight (08) psycho-social counsellors, eight (08) medical records clerks and four (04) revenue collectors. The clinic two (02) cooks, two (02) Laundry staff, two (02) security guards, one (01) out-door gardener and 21 maids (Chelstone Clinic records, 2015).

Healthcare Services offered at Chelstone Health centre: Chelstone clinic offers a number of services to its users. Among the services offered includes the Outpatient Department (OPD), the Inpatient Department (IPD), antiretroviral therapy, Dental services, physio-therapy and mortuary services. It also offers reproductive health services which include Prevention of Mother to Child Transmission (PMTCT), Family

Planning, Voluntary Male Circumcision, and Voluntary Counselling. Some of the services can be drawn from the clinics organisational structure. Chelstone health Centre also conducts a child health week in which they provide routine immunization and vitamin A. The child health week is conducted once a year and is aimed at reaching users that are not reached during the centre hours. During the child health week, the centre also includes areas beyond its catchment area and as such, utilisation figures swell up.

Stakeholders and partners that Provide healthcare services at Chelstone Health Centre: Marie Stopes works with the Centre in the provision of family planning and Male Circumcision. The centre has also partnered with the House of Moses, an where Nurses from the Mother and Child health department at the Health Centre go to give vaccines once a month to children at the orphanage. The health Centre also works with a community based tuberculosis (TB) organisation that deals with TB/HIV users and orphans and gives them food supplements. CIDRZ an NGO has also partnered with Health Centre in the provision of HIV/AIDS, Prevention of Mother to Child Transmission (PMTCT), Mother and Child Health and TB programs. IPAS is another organisation that has partnered with the Chelstone health Centre by providing collaborate comprehensive abortion care. In addition, the Health Centre has engaged the Police to enhance its security. The Lusaka City Council as another partner ensures the provision of water and sanitation and also contributes to epidemic preparedness. Lastly, Chelstone Health Centre partners with schools and conducts school health programs and vaccination programs.

Table 2.1: Top Five Prevalent diseases at Chelstone Health Centre in 2011, 2012 and 2013

No	2011	No. of cases	2012	No. of cases	2013	No. of cases
1	Diarrhoea	447	Diarrhoea	504	Diarrhoea	3063
2	HIV/AIDS	425	RTI non Pneumonia	314	Hypertension	1086
3	Non Pneumonia	397	TB	173	Non Pneumonia	959
4	Pneumonia	183	Trauma	95	Pneumonia	691
5	Malaria	150	Intestinal worms	92	TB	679

Source: (Chelstone Health Centre Action Plan, 2015)

Funding of Chelstone Health Centre: The major source of finance at Chelstone clinic is government funding. In this vein, the district health community office provides grants to the clinics on a monthly basis. The Centre has at times faced the problem of funding after fees were removed. The Health centre did not receive imprest for the fourth quarter of 2013. In addition, grants or imprest was sometimes paid late. As of end of June 2015, the clinic had just received the grant for March 2015. They were still waiting for the grants for April, May and June 2015 (Chelstone Health Centre, 2015). Delay in payment of grants can contribute to poor delivery of healthcare services because primary healthcare facilities now solely depend on government financing. Lack of funds can be a source of poor delivery of services especially at a time when user fees are nonexistent.

MTENDERE HEALTH CENTRE

Mtendere is one of the medium health centres in Lusaka district that started in 1976 through a community initiative. With the increase in population, the health centre extended its services in maternal, child health and delivery services. With the help of the Irish Aids, the maternal, child health and maternity departments were constructed in 1992. In 2005, the Out-Patient Department was extended with the help from the American Corps (Mtendere Health Centre Action Plan, 2015).

Location and catchment population

Mtendere health centre is located 12 kilometres east from the Lusaka District Health Offices. The health centre boundaries with Kalingalinga on the West, Chainama on the North, Chainda on the East, Bauleni on the South and Saint Agnes on the South East. Mtendere Health Centre had a catchment population of approximately 89, 973 in the year 2012 (MoH, 2013). Mtendere health centre's catchment population is divided into ten zones.

Zone one comprises of areas around the Roman Catholic Church, Mtendere Basic School, Kobil Filling Station, and the New Apostolic Church. Zone two comprises areas around the Seventh Day Adventist Church, the football ground, and the Mtendere

Council Library. Zone three of Mtendere's catchment population covers areas around the Kwazulu grocery, Mahatma Gandhi School, Reformed church and Mtendere Market. Zone four includes areas around the So Chabe Tavern, Pentecostal Holiness Church, Chitukuko Basic School, Kamanyi Market, Anglican Church, Mtendere Main Police and Presbyterian Church. Zone five of Mtendere's catchment area includes the Daka Tavern, Pa Niza and the Pillar of Fire.

Zone six of the catchment population consists of areas around the United Church of Zambia, the Baptist Church and Musonda Bar. Zone seven has areas located around Mazimoyo and the African Direction. Zone eight encompasses areas that are near the Christian Mission in Many Lands Church, the CCC and the Christian Reformed Church in Zambia. Zone nine includes areas located around the JICA Water Tank, the Playing Field, Kalikiliki Market, Kalikiliki Police Post and the Council Offices (JICA). Zone ten of Mtendere's catchment population captures areas located near the Prince Chimutu School, Mtendere East Market, Trinity Baptist Church, Full Revival Gospel Church, Catholic Church, Rebecca Bar, Open Car Park, Pa Mwale Shopping Centre and the Seventh Day Adventist Church.

Human resource at Mtendere Health Centre

Mtendere Health Centre has a total of 129 employees stationed at the Centre. The Health Centre has two (02) doctors and seven (07) clinic officers. It has one (01) nursing sister, three (03) registered midwives, and six (06) registered nurses. The Health Centre also has nine (09) enrolled nurses and 11 enrolled midwives. Of the 11 midwives, five (05) are in the Mother and Child Health department and six (06) are in the labour ward. The Health centre only has one (01) certified nurse. The Health centre also has 3 Environmental technologists, two (02) Laboratory technologists and one (01) nutritionist. There are also 7 psychosocial counsellors, two (02) physiotherapists and two (02) dentists. The Health Centre has two (02) revenue Collectors, 9 Clerks, two (02) cooks and four (04) guards. There are 11 general workers, 10 of them work inside the Health Centre and one (01) works on the Surroundings of the Centre.

Health Services and activities offered at Mtendere Health Centre

Among the many services and activities offered at Mtendere Health Centre is the Sexual and gender violence related activities. Though, each department offers specific services to its users. The services and activities offered by the mother and Child Health (MCH) department at Mtendere Health Centre include School health, Health education, Antenatal care, postnatal care and Family planning. The MCH department also offers growth and Monitoring promotion, both static and outreach immunizations, which are also static and outreach. Child health week which is also done by the MCH department is offered twice a year. The MCH department has a sub-division called the counseling and testing. This sub-division offers services including the Elimination of Mother to Child Transmission (EMTC), couple counseling, Syphilis test and Human Immune Virus (HIV) testing.

The maternity ward department at Mtendere Health Centre ensures safe deliveries, conducts domiciliary visits, and infection prevention. The nutrition department activities and services include cooking demonstrations, nutrition defaulter tracing and health education. The largest department is the Out-patient Department (OPD) and it offers clinical care through its four sub-departments. The first sub-department, ART, offers services and activities including HIV and AIDS case management, Voluntary counseling and Testing (VCT), follow ups of missed, quality assurance meetings, and review meetings. The second OPD sub department is the Registry department which keeps records for the health Centre and the clients. The third OPD sub department is the dental care department and it is charged with the responsibility to deal with oral health. The fourth OPD sub division is the Tuberculosis (TB) Corner which offers activities and services such as TB case management, TB defaulter tracing and contact tracing.

Mtendere Health Centre has a Physiotherapy Department which offers rehabilitation, makes ups and offers physiotherapy demonstrations to its users. Another department that offers a myriad of activities and services is the Environmental health department. Its activities and services include the Cholera and Typhoid awareness, contact tracing, door to door education, collection of epidemiological data, school health programmes, follow

up malaria detection cases, salt and sugar monitoring, water sampling, food sampling, vector and rodent control. Mtendere Health Centre also has a Pharmacy Department whose activities and services include the storage of drugs, stock taking and dispensing of drugs to all other departments.

The Health Centre has a Biomedical Laboratory that conducts investigations including the syphilis test (RPR), malaria test (Rapid Diagnostic Test [RDT) and microscopy slides), Urine (Routine microscopy), TB tests, Full blood count (white and red blood cells), liver and kidney function test, sickling test (sickle cell), stool (routine microscopy) and the high vaginal swabs (HVS). Although it is a medium health Centre, Mtendere Health Centre has no In-Patient Department; hence, it refers its users to Kalingalinga Health Centre and the University Teaching Hospital (UTH). Access to the referral Centre's is by road, either by Ambulances or by private arrangements when ambulances are unavailable.

Stakeholders and partners that provide healthcare services at Mtendere Health Centre

Some services that are offered at the Health Centre are in partnership with other stakeholders. The Health Centre has partnered with CIDRZ which offers services such as Anti-Retroviral Therapy (ART) and Cervical Cancer screening clinic. It has also partnered with the Society for Family Health which offers services such as family planning and male circumcision. ZEHRP offers couple counseling and testing over the weekends. African Directions and Kara Counseling offer Voluntary counseling and Testing (VCT) services.

Prevalent Diseases at Mtendere Health Centre

Table 2.2: Top Five Prevalent diseases at Mtendere health Centre in 2012 and 2013

No.	2012	No. of cases	2013	No. of cases
1	Non Pneumonia	16,288	Non Pneumonia	30,280
2	Diarrhoea	468	Skin Infection	4138
3	Malaria	438	Diarrhoea	3134
4	Eye Infection	339	Skin non Infectious	2138
5	Pneumonia	231	Hypertension	1960

Source: (Mtendere Health Centre Action Plan, 2015)

CONCLUSION

In conclusion, Lusaka District or Lusaka city is the capital of Zambia, located in Lusaka province. The city is governed by the elected representatives that form the Lusaka City Council. In addition, Lusaka's population stood at 1,747,152. Poverty continues to affect a number of households in Lusaka with an estimated 24.4% of the population classified as poor. Lusaka has ninety eight (98) registered government run primary schools, twenty five (25) basic and secondary schools. The city also has two hundred and forty (240) community schools. In addition, Lusaka has over 200 private schools. At tertiary level, Lusaka is home to about seven (7) universities. Health service delivery facilities fall into five categories, namely: Health Posts (HPs) and Health Centres (HCs) at community level; Level 1 hospitals at district level; Level 2 general hospitals at provincial level; and Level 3 tertiary hospitals at national level. The city has about six (6) first level public hospitals, thirty (30) public clinics eight (8) health posts and about one hundred and sixty (160) private health facilities (hospitals and clinics). Respiratory infections and diarrhoea are the top two prevalent diseases in Lusaka.

Chelstone Health Centre offered healthcare services to a catchment population of 112,965 users as of 2012. The catchment population comprises users from Chelstone police camp, Chelstone extension, Chelstone compound, former Zambia Airways, Roads Camp and Nkoloma area among others. Chelstone has a total of 150 employees stationed at the centre. On the other hand, Mtendere Health Centre had a catchment population of approximately 89,973 in the same year. Mtendere Health Centre's catchment population is divided into ten zones. Mtendere Health Centre has a total of 129 employees stationed at the Centre.

CHAPTER THREE

CHARGES AND COSTS ENCOUNTERED AT PRIMARY HEALTHCARE SERVICES

INTRODUCTION

Patients have a fundamental right to health among which are availability and access to quality services and facilities. The removal of user fees was meant to eliminate the barriers to accessing healthcare so that users could access primary healthcare free of charge. As such, this chapter documented users experiences of both financial and non financial costs encountered at the health facilities. The main aim of this chapter was to determine and document whether users encountered any charges after user fees were removed on primary healthcare services.

COST OF HEALTHCARE SERVICES AFTER THE HEALTH FEES REMOVAL

Users were asked whether they encountered any user charges. Specifically, users were asked whether they paid for registration, consultation, laboratory tests, x-rays, and to specify any other charges they encountered if any.

With regard to registration, of the 260 respondents, the responses revealed that 93.85 percent were charged for registration. Only 6.2 percent of the users said they were not charged for registration. The 6.2 percent that said they were not charged for registration because they already had a book or card at the health facility they visited and hence did not need to pay. On the other hand, respondents that were charged for registration revealed that they paid K1. The amount charged for registration was the same in both Mtendere and Chelstone townships. Although negligible, any charge that users encounter entails non adherence to the user fees removal policy. Some respondents (4.2 percent) said they could not classify healthcare services as free even after the removal of user fees because they paid K1 as registration charge for a book or card.

On the other hand, it was confirmed that users were not expected to be charged for registration (District Health Team, 2015). The K1 was a mechanism for cost recovery

and users convenience. It was meant to avoid users from having to find or buy a book when they had already arrived at the clinic. In this regard, the K1 registration charge only applied to first time users who did not have a medical record with the Health Center. As such, it can be said that the K1 was once off payment unless a user lost their book or card.

In contrast to the responses on registration, the study found that most users (95.4 percent) were not charged for consultation. Only 4.6 percent said they were charged for consultation. In this vain, the majority users never experienced costs related to paying for seeing a doctor, whether specialist or regular. The responses on consultation match the aim of the removal of users which is to ensure that primary healthcare services at all levels are funded from the general tax revenue and provided free of charge to all citizens (MoH, 2013). Health providers at Health Centres confirmed that no user is charged for consultation.

The responses revealed that some users were charged for X-ray tests at health facilities. Of the 260 respondents, 67 (25.8 percent) said they were charged to undertake the test. But the majority (74.2 Percent) were not charged for X-ray services. This shows that one quarter of the respondents encountered some X-rays charges. Because there is an increase and emphasis by the MoH not to provide medication before ascertaining the cause of ailment, the study concludes that users may experience charges for X-ray services which are often not provided at primary health centres.

In relation to laboratory tests, the responses revealed that some users encountered charges when they undertook a laboratory test such as a malaria test. Although the majority of the respondents (61.5 percent) were not charged for laboratory tests, about forty percent (38.5 percent) had to pay for laboratory tests. It is worth noting that the study did not delve into the different tests conducted at the Health Centres, thus, it was did not establish the actual tests for which users were charged for at the laboratory. The study revealed that despite the removal of user fees, users of primary healthcare services at Mtendere and Chelstone health facilities still experienced charges.

With regard to any other charges experienced at the Health Centre, 2 (0.8 percent) respondents were charged when they underwent a haemoglobin test, 4 (1.5 percent) respondents said that they were charged when they requested for a Medical Report (such as the Road Transport and Safety Agency medical report or Police Medical Report) while 9 (3.5 percent) post natal women were charged for Scanning services (*see table 3.1*). It is important to note that most of the other services that were identified are not primary healthcare services and were provided upon request by the user and hence the charge.

Table 3.1: Responses on user charges at the health facility

<i>Type of service:</i>	RESPONSES					
	YES		NO		TOTAL	
	Freq.	%	Freq.	%	Freq	%
Registration (book/Card)	244	93.8	16	6.2	260	100
Consultation	12	4.6	248	95.4	260	100
X-ray	67	25.8	193	74.2	260	100
Laboratory tests	100	38.5	160	61.5	260	100

Source: Compiled from Field Data, 2015

On the whole, the findings of this study are in contrast to the findings of Masiye et al (2008) who found that none of the respondents paid any money to anyone at the facility for any services that included registration, consultation, drugs and medical examination. Responses in the current study showed that users paid for registration, X-ray and laboratory tests. Rural areas health facilities where Masiye et al conducted their study may have strictly adhered to the removal of user fee policy than their counterparts in urban health facilities.

It is important to note that Health Centres believed that the flexible finances that were previously collected from user fees enabled the Health Center to purchase needy reagents in times that grants from government delayed. This is concurring with the conclusion by Cheelo et al. 2010 who found that income generated from user fees

represented up to one third of resources available at some health facilities. The study concluded that users contributed significantly to financial resources needed by Health Centres in its effective provision of healthcare services. The removal of user fees had affected healthcare delivery to users as is the case at Chelstone Health Centre where the consistent provision of X-ray services was interrupted due to lack of reagents. Reagents for the X-ray departments were easily purchased from funds collected from user fees.

Apart from financial charges, the study found and documented other forms of payments that users encountered at health facilities. The study found that users were provided Gloves, syringes, and sanitizers. Specifically, the responses revealed that 18.1 percent were requested to provide gloves. 16.2 percent said they were told to provide their own injection syringe. The highest proportion that encountered in-kind payments had to provide sanitizers and these constituted 22.3 percent of the respondents. The provision of in-kind items was especially common among post-natal users.

Table 3.2: Responses on requested in-kind items at health centres

<i>Type of in-kind item</i>	RESPONSES					
	YES		NO		Total	
	Freq.	%	Freq.	%	Freq	%
Gloves	47	18.1	213	81.9	260	100
Injection Syringe	42	16.2	218	83.9	260	100
Sanitizers e.g soaps	58	22.3	202	77.7	260	100

Source: Compiled from Field Data, 2015

The study found that the demand for in kind payments were attributed to inability by the Heath Centers to provide such materials. User fees previously had the potential to improve access to better quality services. The extra revenue that was generated from fees was re-invested into the health system and it helped to cover the costs of stationery, sanitizers and repair and maintenance of electrical appliances among others (Chelstone Health Centre, 2015). Revenue earned from user fees was also seen as significant when government systems failed to adequately move funds to the peripheral levels. There are other unforeseen costs that were previously covered by user fees, including

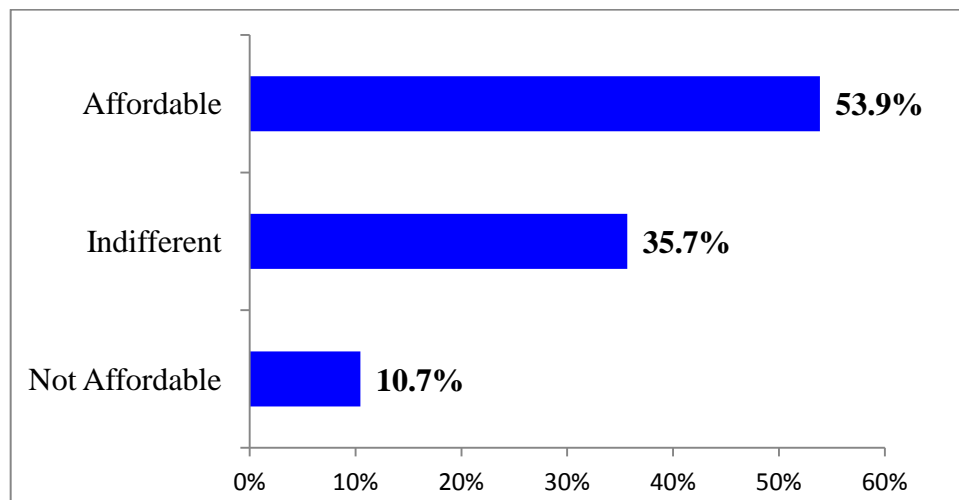
transportation of users using hired private vehicles when the ambulance was not available. Further, the grants given to the clinics by the government may not cover all the clinical costs. Ultimately, now that user fees are removed, effective delivery of healthcare is fraught at health centres. Users as receivers of healthcare experience poor quality services, and at times, the service is unavailable due to lack of funds.

The findings on in-kind charges faced by urban Health Centre Users are similar to the conclusions of Chama-Chiliba (2014) who argued that removing user fees had led to cost shifting, resulting in additional costs for pregnant women. Moreover, with the abolition of fees, women were required to provide their own supplies, including bleach, gloves, and syringes to be used when delivering at a health facility.

AFFORDABLE HEALTHCARE

The study documented respondent's experience of how affordable healthcare is after the fees were removed. The responses showed that most (53.9 percent) of the users experienced affordable healthcare services. The responses also revealed that 35.7 percent of the users could be indifferent on whether healthcare was affordable or unaffordable. Nevertheless, 10.46 percent of the users still found the services as unaffordable even after fees were removed (*see figure 3.1 that shows responses of affordability*)

Figure 3.1: Responses on Affordability of Healthcare after the removal of user fees



Source: Compiled from Field Data, 2015

The responses thus show that despite the removal of user fees, some of user's still find healthcare services to be unaffordable. This may be due to cost incurred in an effort to access healthcare such as transportation costs. The responses showed that 64.6 percent (166) walked to the health centres, while 35.4 percent (96) of the respondents used a public bus, taxi or a private car. The responses showed that respondents that used a public transport spent an average of about K56.3. Although transportation costs are not directly affected by the removal of user fees, they still pose a barrier to accessing free healthcare and may still take up a share of the user's finances, as they seek healthcare. The experiences of users in Lusaka correspond with the conclusion of Morestin & Ridde' (2009) that some costs such as the transportation to health facilities were not covered by the healthcare fees abolition policies. There is need to ensure that policies in the different sectors of the country are complimenting each other because an increase in transport costs will have a direct influence on the ability of users to access healthcare especially for users furthest in the catchment population.

In addition to experiences the affordability of healthcare, the study also documented responses on how respondents rated the fees they encountered after the removal of user fees. The responses showed that 13.8 percent of the users found fees as too expensive. But, 86.2 percent of the respondents said they never experienced a time of fees being expensive after the removal of user fees. Further, on costs encountered health facilities, the study delved into respondents' experience of ability to pay on healthcare services. The responses showed that less than 5 percent of the respondents failed to pay for particular services. Table 3.3 shows the documented cases of respondents that were still unable to pay for services that were charged.

Table 3.3: Responses on failure to pay for health services

	YES		NO		TOTAL	
	Freq.	%	Freq.	%	Freq	%
Registration (book/Card)	11	4.2	249	95.8	260	100
Consultation	5	1.9	248	98.0	260	100
X-ray	11	4.2	249	95.8	260	100
Laboratory tests	7	2.7	252	97.3	259	100

Source: Compiled from field Data 2015

Further, the study found that that 7 out of the 11 respondents that failed to pay the K1 for registration were unemployed, 1 was a student, another 1 was self employed and 2 were employed. In a similar manner, 4 out of 7 of the respondents that failed to pay for laboratory tests were unemployed. 1 was a student and another 1 was self employed. There was also 1 respondent that was employed that said they failed to pay for laboratory tests. The study concluded that one's employment situation may have an influence on their ability to pay for health services.

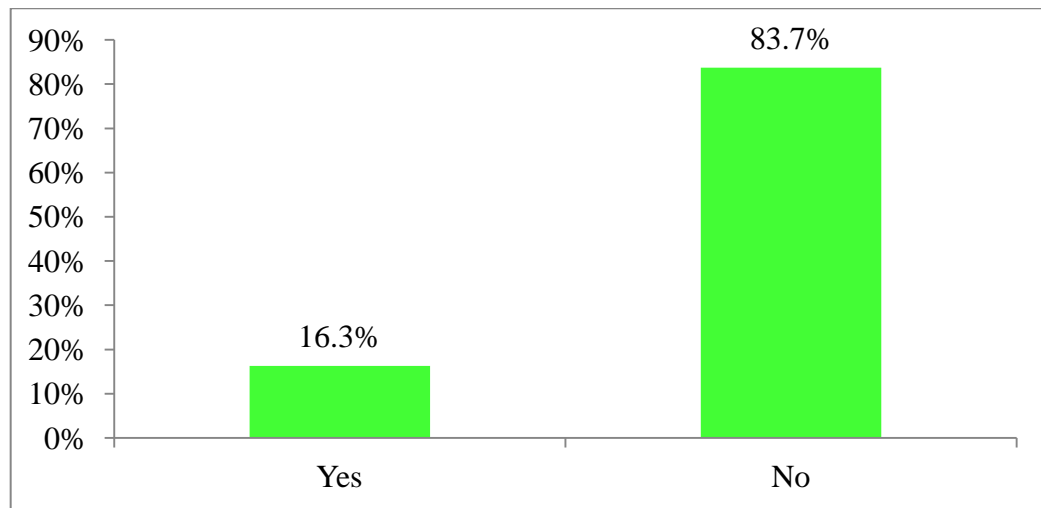
HEALTH SERVICES OFFERED FREE OF CHARGE

The study documented users' experiences on whether they classify health services as being offered 'at no fee' or 'free of charge'. The responses revealed that 68.3 percent of the users could neither classify their experience as being 'free' nor offered at no fee. Only 31.8 percent of the users in classified the health services as offered at 'no fee' or 'free of charge'.

The responses imply that when users experience any costs when seeking care, they cannot classify healthcare as free despite the government having removed user fees. This view is similar to the findings of DFID (2010) which concluded that users experienced informal charging of user fees including charges for registration, as such, many people did not perceive care to be free of charge. The majority of responses in urban areas also portrayed a similar view.

Users' responses on whether healthcare is offered free of charge also implies a user's lack of isolation of the charges that users experience at the Health Centre from the costs they incurred outside the Health Centre such as transport costs and private pharmacy costs. The study revealed that it is likely that users interpreted the charges experienced even outside the clinic as user charges (such as transport costs), hence, they did not classify free healthcare as free. Users were not charged for consultation and drugs collected but were charged for registration, laboratory tests and non primary healthcare services such as a Police Medical Report.

Figure 3.2: Responses on whether health services offered free of charge



Source: Compiled from Field Data, 2015

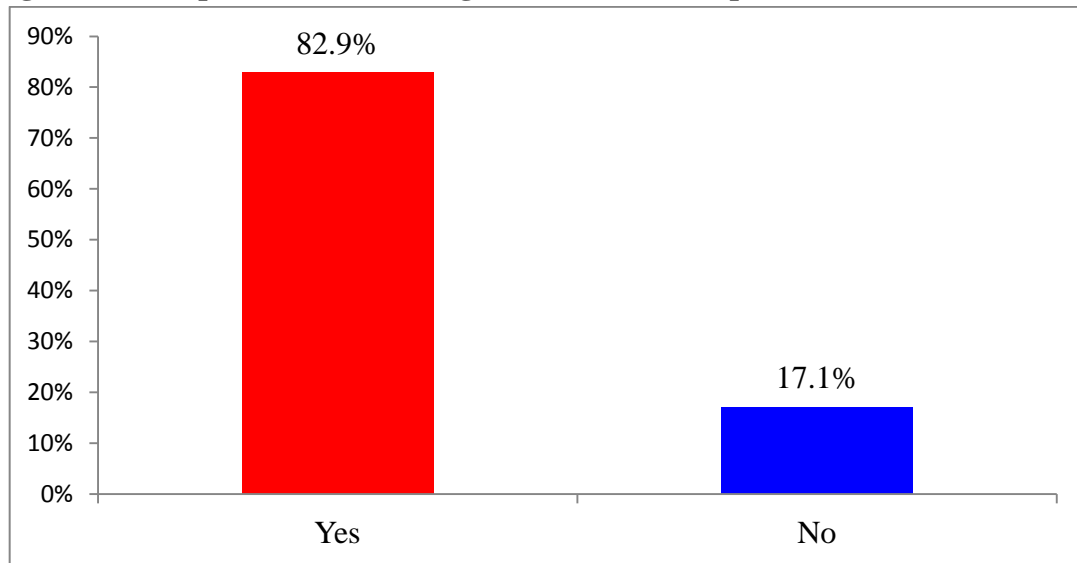
Based on their experiences in the three years of no user fees, respondents were asked whether the government should continue providing free primary healthcare services or to revert to user fees. The responses revealed that the majority of the users wanted the government to continue providing free healthcare services. This was echoed by 82.9 percent of the respondents. However, 17.1 percent said that the government should revert to the use of user fees.

When categorised into major themes, most users wanted the government to continue providing free healthcare services because the majority of Zambians are poor. Specifically, the major themes that developed were that *“not everyone can afford to pay for user fees”*, *“everyone is able to collect drugs at health centres”*, *“many people are unemployed”*, *“the aged and widowed cannot afford”*, and *“access is guaranteed even in times of emergency”*. Many reasons behind keeping healthcare services free were based on affordability. The findings of this study coincide with the findings of Mostine and Riddie who concluded that the abolition of fees had achieved its main objective of utilization of services (especially primary care visits and assisted deliveries) particularly among the poor and that people appreciated the abolition of fees.

On the other hand, respondents that wanted user fees to be reintroduced said that healthcare had deteriorated and hence there was need for users to contribute to improve

the quality of the service delivered. Of the 44 respondents that said that user fees must be reintroduced, 17 were employed, 7 were self employed, 14 were unemployed, 4 were students and 2 were retirees. In addition, some respondents felt that users were able to pay for the services because user fees were not exorbitant.

Figure 3.3: Responses on whether government should provide free health services



Source: Compiled from Field Data, 2015

CONCLUSION

The study concluded that 93.9 percent of the user's responses showed that they were charged for registration. The amount charged for registration was K1. However, the K1 registration charge only applied to first time users who did not have a medical record with the Health Center. As such, it was once off payment unless a user lost their book or card. 38.5 percent of the users reported that they were charged for laboratory tests. One quarter of the respondents said they were charged to undertake an x-ray test. On the other hand, only 4.6 percent said they were charged for consultation. Any charge to users encounter entails non adherence to the user fees removal policy meant to provide free primary healthcare services to all Zambians.

Other charges experienced at the Health Centre, 2 (0.8 percent) respondents were charged when they underwent a haemoglobin test, 4 (1.5 percent) respondents said that

they were charged when they requested for a Medical Report (such as the Road Transport and Safety Agency medical report or Police Medical Report) while 9 (3.5 percent) post natal women were charged for Scanning services. The study concluded that users encountered some in kind charges. About 18.1 percent of the respondents were requested to provide gloves. Another 16.2 percent had to provide their own injection syringe and 22.3 percent of the respondents had to provide sanitizers.

The study also concluded that 10.5 percent of the users still found the services as unaffordable even after fees were removed. The study further concluded that 13.8 percent of the users found fees as too expensive. But, negative comments and experiences about cost were on the whole quite rare.

CHAPTER FOUR

WAITING TIME AT URBAN PRIMARY HEALTH CENTRES

INTRODUCTION

This chapter brings together information on waiting time users experienced when accessing public primary health care services at a health centre. This chapter also documents the relationship of waiting time experienced by users with their experience availability of human resources at health centres. This chapter focused on waiting time and adequacy of human resource because the government aims to provide a continuum of quality effective health care services, as close to the family as possible in a quick, competent and caring manner.

USERS' EXPERIENCE OF TIMELY HEALTHCARE SERVICE DELIVERY

This section documented the time spent by users at health facilities. In this section, the experiences of the time that users spent at a health facility after the removal of user fees were compared to the experiences of users before the fees were abolished.

Time spent waiting to see a Doctor or Clinic Officer

To establish the waiting time, Users were asked to estimate how long they waited before they were attended to by a doctor, clinic officer or nurse. The responses revealed that the mean average time spent waiting at a Health Centre was about 110 minutes. This implies that users spent more than 48 minutes above the time that users experienced before the removal of user fees. The Ministry of Health (2007) reported that waiting times for Urban Health Centres was 62 minutes. As such, responses indicated that there is a significant increase in waiting times after the removal of user fees. (*Table 4.1 shows the waiting before the removal of user fees*).

Table 4.1: Ministry of Health Statistics of Time spent by Patients, 2006

Waiting Time	RHC	UHC	Hospitals	All
Ave. waiting time (minutes) of patients	54	62	92	65
Maximum waiting time (minutes) reported	300	360	480	480
% who said waiting time is reasonable	66	63	49	61
% who said waiting time is too long	32	34	48	36

Source: (Ministry of Health, 2007)

When users are subjected to long waiting times, they may exacerbate their health conditions. The study found that the long waits were closely associated to opening time of health centres. Health centres opened at 08:00hrs but 48.4 percent said that they arrived at the health centre several minutes or hours before 08:00hrs. This was because of the increased utilisation levels and hence users increased the chances to be attended earlier by going to the health centre before the opening time. As such, the respondents that reported earlier than the opening time experienced a longer waiting time.

Further, when users are subjected to long waits, they may shun utilising Health Centres. But, because of the removal of user fees, it is likely that although a significant number of users may turn away from healthcare services due to long waits, the number of users of health centres may still increase because healthcare is free. In other words, there will be as many users that utilised healthcare services, as well as those that did not utilise healthcare services due to long waits.

The study found a significant difference in the time spent by resident of Chelstone and those of Mtendere townships. A user in Chelstone spends an average of 58 minutes where as a user at Mtendere Health Centre spent an average of about 160 minutes before they were attended to. Using a Two-sample t-test with equal variances at 95% level of significance, the study found a difference of the time spent waiting at Mtendere Health Centre as compared to Chelstone Health Centre was 102.35 minutes and the P-value was 0.00. Because the P-Value is below the level of significance of 0.05, the difference in mean waiting time is statistically significant. The difference in mean waiting time can be attributed to the high density nature of Mtendere. Because Mtendere is characterised by unplanned settlements, it is more likely that the health centre is overcrowded due to increased utilisation after the removal of user fees.

Time spent waiting for Laboratory or X-ray results

Still on waiting to receive a service, the study documented respondents experience in terms of how long they waited to receive results of the tests they undertook. The responses revealed that respondents that underwent a Laboratory tests waited for about one hour (1:08 minutes) before they were given their results. The study also revealed

that those that took an X-ray test waited longer to get results. It took respondents an average of about one hour and thirty minutes (1:34 minutes) to get their results.

Table 4.2: Responses of average Waiting Time for tests results

Type of Test	Mean (mins)
Laboratory	68.4
X-ray	94.0

Source: (Compiled Field Data, 2016)

TOTAL TIME SPENT AT THE HEALTH CENTRE

The study documented the experiences of users with regard to time spent with a doctor or clinic officer. The responses showed that most users (66.2 percent) usually spent enough time with the health providers (*see table 4.2 for further details*). When users are availed enough time to see a health professional, they have ample time for a complete diagnosis which is important if their health problems are to be resolved. The responses in this study reveal a similar conclusion by Tufton & Waller who argued that the majority (65.5 percent) users in Jamaica felt the abolition of users fees had not been affected by the time spent with a doctor.

Table 4.3: Responses on time spent with Doctor or Clinic Officer at health facilities

<i>Time spent with health professionals</i>	RESPONSES	
	Freq.	%
Never	11	4.28
Sometimes	30	11.67
Usually	170	66.15
Always	46	17.90
TOTAL	257	100

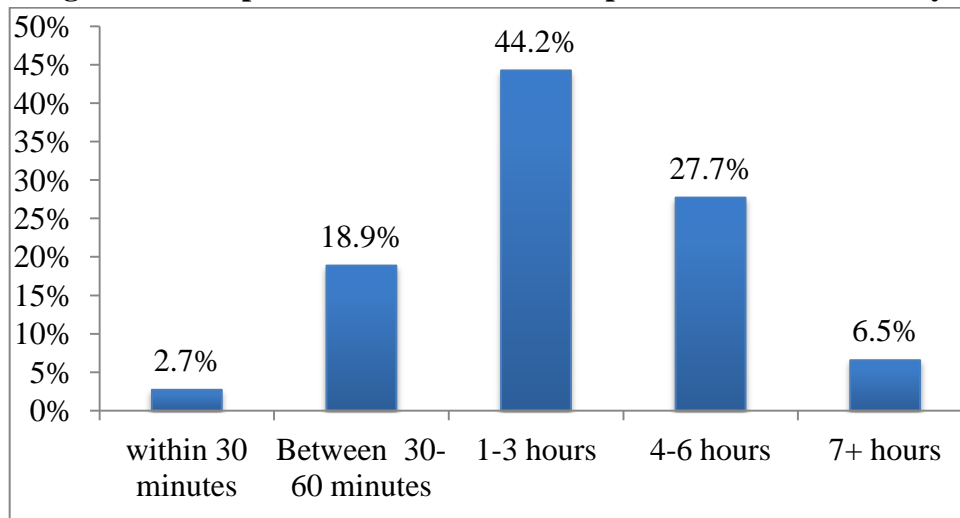
Source: (Compiled Field Data, 2016)

Apart from the time spent with the doctor or clinic officer, the study established the total average time spent that users spent at an Urban Health Centre. The responses revealed that on average, most respondents (44.23 percent) spent between one (1) hour to three (3) hours as the total time at a health centre 18.85 percent said they spent between 30 to

60 minutes at the health centre. 27.69 percent of the respondents spent between 4 to 6 hours at a health centre and 6.45 percent of the respondents said they averaged over 7 hours at a health centre. Only 2.69 percent of the respondents said they left the health centre within thirty (30) minutes of their arrival at the health centre.

As already earlier alluded, users can underutilise certain services due to opportunity costs that come with time spent at the health facility. It is important for government to come up with mechanisms to reduce long waiting and time spent at health facilities. Such mechanisms will complement the removal of user fee policy. According to the UNDP (2011), the promotion of timely health care delivery should be part of the continuum of health services vital for long and healthy lives.

Figure 4.1: Responses on the Total Time spent at the health facility



Source: (Compiled Field Data, 2016)

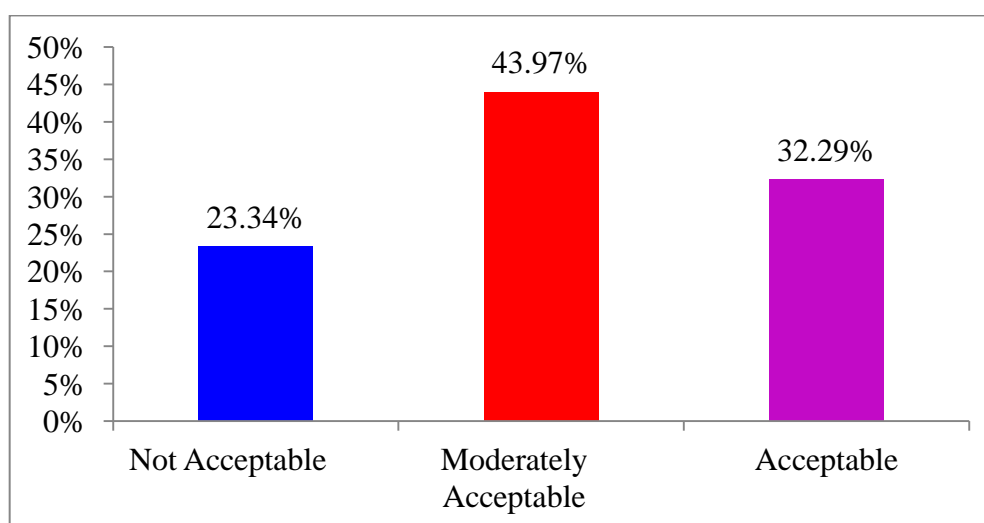
ACCEPTABLE WAITS AT HEALTH FACILITIES

The study documented how appropriate users found the time spent at Health Centres. Users were asked to rate their experience with time spent at the Health Centre. The responses of the study revealed that the general experience of both the users in Chelstone and Mtendere is 'moderately acceptable' and this was echoed by 44 percent of the respondents. 29.9 percent of the respondents said that there experience with waiting time was acceptable.

But, there were more respondents in Chelstone (40 percent), who experienced ‘acceptable’ delivery of services in comparison to users in Mtendere (19.7 percent). 23.4 percent of the users rated the time spent at the clinic as ‘Not Acceptable’. The responses in this study have a similar outcome with the findings of the Ministry of Health 2007. In 2007 before the removal of user fees in urban areas, the Ministry of Health reported that 63 percent of the users found the waiting time at health Centres as reasonable. According to the Ministry of Health (2007), 63 percent of the users felt that the waits were reasonable. In this study, it was also found that an aggregate of about 74 percent of the user found the waiting time as acceptable. (43.97 percent said moderately acceptable while 29.85 percent said the waits were acceptable).

The responses were also analysed by area with Chi-Square analysis which was fitted at 95% (0.05) level of significance, the P-value showed an outcome of 0.003. This suggests substantial differences in experiences of waiting time and overall time spent at the health centers between Chelstone and Mtendere Health Centre users. As a result of the longer waits at Mtendere health centre, some users in Mtendere utilised services from other Health Centres such as Kalingalinga and Chainama. Such experiences of having to utilise other health centres due to long waits were rarely echoed by Chelstone Health Centre users.

Figure 4.2: Responses on rating of the time spent at the health centre



Source: (Compiled Field Data, 2016)

The responses on waiting time that were categorised into themes showed that users had four major issues of concern that led to long waiting times. Firstly, users experienced a lack of priority by nurses and doctors to deal with serious cases. Secondly, users also experienced inconsistency especially by the nurses who were not dealing with users at 'first come first serve' basis. Lastly, users observed that health professionals spend a considerable amount of time on non work related activities such as socialising while users were waiting to be attended to. The fourth concern was an increased mushrooming of residential plots around Mtendere. In Chelsone, the increased utilisation was also a result of an addition of more catchment areas called Obama. The increase in utilisation is seen to be contributing to the increased number of users at Health Centres.

It is worth noting that even the key informants attributed the increase in the waiting time to the increase in utilisation of services. It was revealed that health facilities had been overwhelmed by the influx of people. The contributing factors to longer waiting include people's desire to visit a Health Centre even when they had a minor problem such as a headache. After the removal of user fees, users visit the Health Centres with cases that they previously dealt with in homes (District health Team, 2015).

Overall, the study findings were similar to the findings of Tufton & Waller (2013) where users reported that service delivery was ineffective and inefficient with nurses and doctors displaying an apathetic attitude towards patients and their general duties. The service had not only gotten progressively worse but also exceedingly slow. Tufton and Walker also concluded that users felt better quality and faster service would be given if fees were paid.

AVAILABILITY OF HEALTH PERSONNEL

The availability of health personnel in the right numbers ensures and reduces the patient-doctor ratio. However, even with the right number of health personnel at health facilities, increased utilisation that exceeds the health facility establishment design has the ability to affected waiting time because one health personnel will attend to more than the prescribed estimate. Both Chelstone and Mtendere Health centres had reported an increased flow of patients after the removal of user fees to more than double the

establishment design at Chelstone Health Centre and almost double at Mtendere health Centre. In 2012, Chelstone Health Centre was providing health services to 102, 423 users and Mtendere Health was providing Health services to 89, 973 users but Urban Health Centres are designed to provide health services to a catchment population of 50, 000 (MoH, 2013).

The study also documented respondent's experience of available of health personnel. Of the total 260 respondents, the study found that 86.7 percent had never experienced a time when they there was no one to attend to them. But 13.3 percent of the respondents experienced a situation where there was no health personnel to attend to them. Although the majority of the respondents never experienced a time where there was no one to attend to them, the 13.28 percent revealed a similar outcome to the findings of the Ministry of Health. In a report by the Ministry of Health (2007), it was reported that that staff absenteeism is considerable. They reported that 9.6 percent of staff was not in the health facility during their survey. Specifically, their report revealed that 12.8 percent of health personnel in UHCs were unavailable during their survey. When health workers are absent or unavailable to attend to users, efficient and effective healthcare delivery may be weakened.

On the other hand, users were also asked about their experience on the adequacy of personnel to attend to them. The responses revealed that about three quarters of the users experienced inadequate staff at the Health Centre they visited (74.22 percent). In contrast, 25.78 percent of the user responses revealed that there were adequate personnel at the health centres. The experience of inadequacy of personnel at the Health Centres not only leads to longer waiting times on the part of users but also leads to increased workload on the part of health workers leading to ineffective health care service delivery. Further, disproportionate numbers of doctors and patients can also cause a bottleneck in the queue for service.

Influence of adequate personnel on waiting time

In order to find out whether adequacy of personnel has an influence on the waiting time, responses on time spent and adequacy of personnel were cross tabulated. The responses revealed that 54.6 percent of the respondents that said the time spent was *just right* also said that there were adequate personnel that attended to them. Although 34.9 percent of the respondents that said their visit were *too long* said there were adequate personnel to attend to them. Only 10.6 percent that said there were adequate personnel said the time spent at the health centre was *too short*. In other words, an aggregate of about 65 percent of the users that said that the waits at the Health Centre were short or just right also said that there were adequate personnel to attend to them.

On the other hand, a cross analysis showed that 54 percent of the respondents that found the time spent at the health centre also reported and described their experience as at the Health Centre they visited as having inadequate personnel. Although 39.7 percent found their visit to the health centre as just right, they did think there were adequate personnel to attend to them. 6.4 percent of the respondents described their visit to the health centre as too short. Despite finding the time spent as short, they described their experience on adequacy of personnel as inadequate (*see table 4.4*).

Lack of health personnel, absenteeism and insufficient training of health workers can result in the health services offered being of inadequate clinical quality. Human resources are critical to the delivery of effective healthcare services. The lack of adequate professional health workers in the right mix contributes to poor and ineffective healthcare delivery. In the 2011-2015 national plan, the government of Zambia aims to improve the availability and distribution of qualified health workers in the country (MoH, 2011). Therefore, effective healthcare delivery should ensure that there is a balance between the demand side (users) and the supply side (health workers) if the healthcare services provision is to be effective. Effective diagnosis and provision of information to users can be hampered by poor doctor-patient ratio. This ultimately may affect time spent at a health centre.

Table 4.4: Responses of influence of adequate personnel on waiting time

Characteristic		<i>Responses on how respondents described the adequacy of personnel</i>		
<i>Responses on how respondents described their time spent at the clinic</i>		YES	NO	Total
Too short	Freq.	7	12	19
	%	10.61	6.35	8.48
Just right	Freq.	36	75	111
	%	54.55	39.68	47.12
Too Long	Freq.	23	102	125
	%	34.85	53.96	44.41
Total	Freq.	66	189	253
	%	100	100	100

Source: (Compiled Field Data, 2016)

The responses led to the identification of a multiplicity of causes of inadequacy of personnel that contribute to longer waiting times. To begin with, it is worth noting that that despite the need for more staff, each establishment has a number of staff that is allocated to it. However, having a defined number of staff in the view of the clinics does not take into account the exceedingly higher utilisation that has resulted from the removal of user fees. For example, in Mtendere, the removal of user fees also entailed an increase in services provided. The clinic needed more employees (in the ART Department) to undertake the new added services, but at the time the study was conducted; the human resources were still not allocated to the health centre. This was three years after the implementation of the removal of user fees and introduction of new services.

Delay in the provision of additional required human resources at Mtendere Health centre may have been exacerbated by the old health centre's human resource establishment records which had not been updated or upgraded. The old human resource establishment

requirements did not cater for newly added services. As such in the district health system, Mtendere Health Centre had the required human resources when in fact, they did not. This has resulted in the Health Centre not having the required personnel because the new services did not match with centres' old establishment human resource requirements. In addition, the deficit in health personnel and delay to fill the gap may have been exacerbated by the two years employment freeze. Employment freeze meant that government could not employ more staff at the time when utilisation had increased. Ultimately, health centres had to utilise the existing health workforce to cope with the increased levels of utilisation.

On the whole, only the area of residence among the social demographic characteristics influenced the responses. There significant differences in the times that people waited and overall time that people between Mtendere and Chelstone health centre users. Users' of Mtendere health Centre were more likely to wait longer for a doctor to attend to them as well as the overall time spent at a health facility. Using a Two-sample t-test with equal variances at 95% level of significance, the mean difference of the time spent waiting at Mtendere Health Centre as compared to Chelstone Health Centre was 102.35 minutes and the P-value was 0.00. The mean difference in waiting time was statistically significant.

CONCLUSION

Based on user responses, the study concluded that users spent 2 hours (110 minutes) waiting to be attended to at a health centre. This implies that they spent more than 48 minutes above the time that users spent before the removal of user fees. The Ministry of Health (2007) reported that waiting times for Urban Health Centres was 62 minutes. Long waits have been known to lead to increased worry, anxiety, stress and pain. In comparison to the study of the Ministry of the Health in 2007 on waiting time, the responses showed that there is an increase in the number of users who felt that the waiting time at health centres was reasonable. 44 percent said the waits were moderately acceptable while 29.9 percent said the waits were acceptable. Further, the responses revealed that on average, users spent 3 hours (172.03 minutes) as the overall time at the

health centre. Specifically, the majority of the respondents (44.3 percent) spent between 1 to 3 hours at the health centre. Only 2.7 percent of the respondents said they left the health centre within thirty (30) minutes of their arrival at the health centre. The study concluded that there are substantial differences in experiences of waiting time and overall time spent at the health centers under review.

CHAPTER FIVE:

AVAILABILITY OF DRUGS/MEDICINES AT HEALTH CENTRES

INTRODUCTION

This chapter focuses on the availability of drugs at primary Healthcare Centres. The aim of this chapter is to document the extent to which users had access to prescribed drugs. It is essential that medicines satisfy the priority health care needs of the population. Drugs should be available within the context of functioning health systems at all times at a price the individual and the community can afford. When medicines are not available in the public sector, patients will have to purchase medicines from the higher-priced private sector, or forgo treatment altogether. Since health facilities at a primary level generally provide drugs free of charge, they are especially important for providing access to drugs for the poor. The availability of drugs at health facilities is very important because the, lack thereof can deter users' recovery process after diagnosis.

USERS EXPERIENCE OF DRUGS/MEDICINES AVAILABILITY AT HEALTH FACILITIES

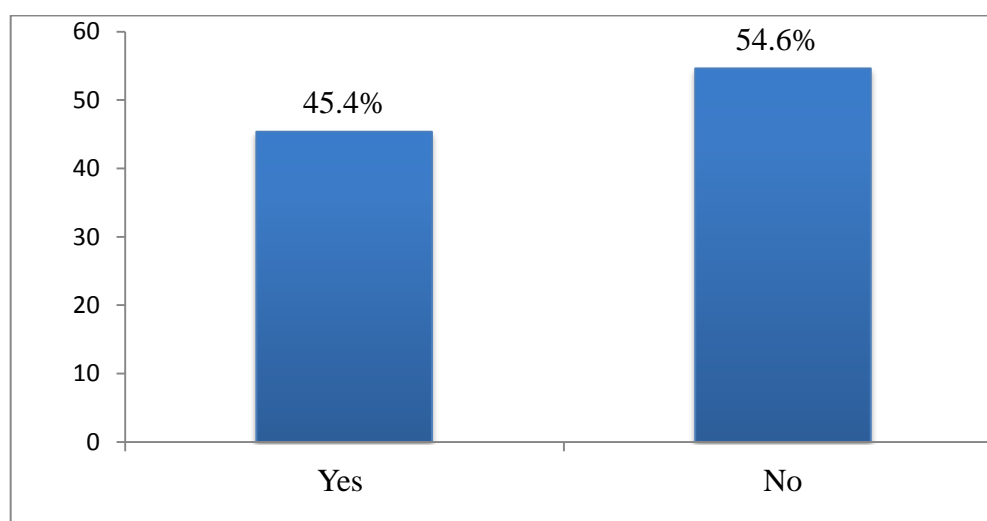
To examine the extent to which users had access to prescribed drugs, the study documented respondents' experience with respect to availability of drugs. Users that were given a prescription at that visit/s to the health Centre were asked whether the prescribed medication was available at the clinic pharmacy.

Of the 260 respondents that were given a prescription, 216 (83.1 percent) of the users were given a prescription at their visit to the Health Center. Out of the 216 respondent that were given a prescription, 54.6 percent did not find the drugs at the Health Centre's pharmacy. This means that only 45.4 percent of users that were given a prescription found all the drugs prescribed at the Health Centre's pharmacy. This implies that more users leave Health Centres with prescriptions, rather than drugs thereby weakening the removal of user fees policy. The policy is weakened because the Health Centers become institutions for effective diagnosis and not drug provision. However, full recovery for a user demands both diagnosis and availability of drugs.

Shortages of drugs are highly frustrating for everyone involved, including pharmacists, physicians, nurses, and patients. Consequently, drug shortages can compromise relationships with colleagues or patients when frustrations are misdirected. Users may not have a good experience of healthcare service when drugs are unavailable.

The findings of this study concur with the conclusions of Masiye, et al (2008) where nearly 20% of users in rural areas said drug availability had worsened. They reported that users were simply given a prescription and told to fill in the prescription elsewhere because not all types of medication are available at the health centre. The ZDHS (2014) revealed that 39.5 percent of women were concerned that there might be no drugs available at Health Centres. Women not only experience healthcare services when they visit the clinic, most women also take the leading role of ensuring that children receive medical treatment. As such, their experiences are vital to understanding availability of drugs at health centres.

Figure 5.1: Availability of prescribed drugs at the clinic



Source: (Compiled Field Data, 2015)

Health Centres confirmed that drug supply even after the removal of user fees had been consistent. Health Centres were now overwhelmed with the increase in utilisation since the quantity of drugs that was provided prior to the removal of user fees was still the same. This is in contrast with Onde's finding who argued that drug provision had increased in the period after the removal of user fees in rural areas in 2006. This study found that there was no increased the drug supply. Demand has risen, but supply has

remained constant. The resultant effect is that at times, the Health Centre runs out of stock before they were restocked at the end of the month (Health Centres, 2015). The findings of this study were consistent with Meessen, et al. (2009), who in 2008, two years after the removal of fees in rural areas, reported that the removal of user fees was not accompanied by additional procurement of drugs. Thus, urban Health Centres receiving the same quantity of drugs as before the removal of user fees is not odd.

Similarly, Morestin & Ridde (2009) argued that the experience of shortage of drugs is not unique in this respect: South Africa, Madagascar, Uganda and Ghana also reported problems with drug availability after fees were abolished. The experiences of lack of drugs after the fees removal in rural areas in Zambia and in other countries should have been used as a benchmark for the implementation of the policy in urban areas.

Further, recognising that fees are a barrier to accessing healthcare is one problem, removing user fees to increase utilisation is meant to redress the financial barrier. But, providing the same quantity of medication after the fee removal may be seen as an oversight on the effect of actions undertaken. Although affordability and access is a key determinant in the improving access to medicines, its availability, adequacy and sustainability in its provision are also required. As was the conclusions of Tufton and Walker (2013) who reported that users felt that better quality and faster service would be given if fees were paid, the responses in this study showed that some users felt that fees should be reintroduced, if the lack of drugs is a direct result of the removal of user fees.

The study document respondents experience with regard to charges of drugs at the health centre pharmacy. Of the 98 respondents that collected drugs at the health centre pharmacy, showed that 82 (83.5 percent) said they were not charged for any drug/s that they were given. But 16 (16.50 percent) respondents said they were charged for the drugs that they collected at the clinic pharmacy. Of the 16 respondents that recalled being charged for drugs even after fees were removed, five (03) said they could not recall how much they were charged, eight (08) said they were charged less than K10, one (01) was charged K15, three (03) said they were charged K20, one (01) was charged K35 and two said they were charged K40. It was unclear whether these respondents recalled a time before or after fees were removed. It was unclear because both health

centre pharmacists and district health officials reported that drugs were given free of charge after fees were removed. In the view of health workers and district health team, users only encountered drug related costs when they purchased drugs that were not available at the health centre.

But, the implication of free drugs was seen as a hazard by some health providers. At health Centres, health practitioners had observed that removal of drugs charges has promoted what they termed as a moral hazard on the part of users. It was a moral hazard because users visited Health Centres to collect drugs at no fee. There was a lack of responsibility by users because they were not charged. Such behaviour contributed to the depletion of drugs at health centres. The views expressed by health providers are similar to the report by Hardley (2011) who found that users were frivolously using and sharing drugs in the community.

BUYING DRUGS FROM PRIVATE CHEMISTS, PHARMACIES OR DRUG STORES

The study documented cases of respondents who bought drugs that were not available at their Health Centre from a private chemist, pharmacy or drug store. The responses revealed that nearly all the users (94.1 percent) did not find drugs at their Health Center had to buy their medication from a private chemist, pharmacy or drug store. However, 5.8 percent said they did not utilise the services of a private chemist, even though the drugs were unavailable at the clinic.

Since health facilities at a primary level generally provide medicines free of charge, they are especially important for providing access to medicines for the poor. On the contrary, the implication when medicines are not available in the public sector is that patients will have to purchase medicines from the higher-priced private sector, or forgo treatment altogether. The essence of the removal of health user's fees was to remove the barriers to accessing healthcare services. The access to drugs after the removal of user fees can only realised if the drugs are available at Health Centres.

Subjecting users to buying drugs from private pharmacies subjects them to unfamiliar alternative sources which increase the risk of procuring counterfeit medications. Some users expressed concern at the inability to determine a product's source.

There seemed to be a negative perception among some users that some employees at the health facility may be in partnership with owners of private chemists or drugs stores. Users accused workers at the health facility of knowing exactly which private pharmacies users could find prescribed medication that was unavailable at the health Centre. Further, users felt the lack of drugs is a result of drugs having been taken by health workers at their facility and being sold in drug stores. Users expressed concern at private chemists, especially in Mtendere where these private drug stores are strategically located a few metres away from the Health centre.

Table 5.1: Responses on buying drugs from Private Chemists

<i>Respondent were asked whether they bought drugs from drugs that were unavailable at primary healthcare centres:</i>	RESPONSES	
	Freq.	%
Yes	(192)	94.11
No	(12)	5.88
TOTAL	204	100

Source: (Compiled Field Data, 2016)

COST OF DRUGS

Users that bought drugs at a private chemist, Pharmacy or drug store, were asked: How much they paid for medication they bought?

The responses showed that on average, the users of Health Centres spent K43.8 on drug related charges. The drug charges at private drug stores show cost barrier which the removal of user fees was aimed to redress. The average amount spent on drugs shows a much larger magnitude than user fees. There is need for functioning health systems to have drugs at all times in adequate amounts, in the appropriate dosage forms and with assured quality. There is also need for the government to provide supportive policies to the removal of user fee policy. In order to reduce health costs, the government needs to

realise that there are several players that compliment their efforts. As such, drug costs can be reduced by reducing taxes on drugs, since they cannot always provide all the necessary drugs to users. Reduced drug cost should entail a price that individuals and the communities can afford.

Users' capacity to pay for Drugs

In addition to costs that were encountered on drug related charges, the study also documented respondents' ability to pay for drugs that were not available at health centres. As such, respondents were also asked whether they experienced a time where they did not take prescribed medication because they could not afford the cost of drugs in three years of no users fees. The responses revealed that more than half of the respondents (56.20 percent) had never experienced inability to pay for drugs. But, 30.62 percent said they sometimes experienced inability to pay for drugs hence they were unable to take medication prescribed to them by the doctor or Clinic officer.

Table 5.2: Responses on capacity to pay for Medication

<i>Responses on times users did not take medicines prescribed because of its cost:</i>	RESPONSES	
	Freq.	%
Never	145	56.2
Rarely	11	4.3
Sometimes	79	30.6
Often	2	0.8
Very Often	7	2.7
I don't Remember	14	5.4
TOTAL	258	100

Source: (Compiled Field Data, 2016)

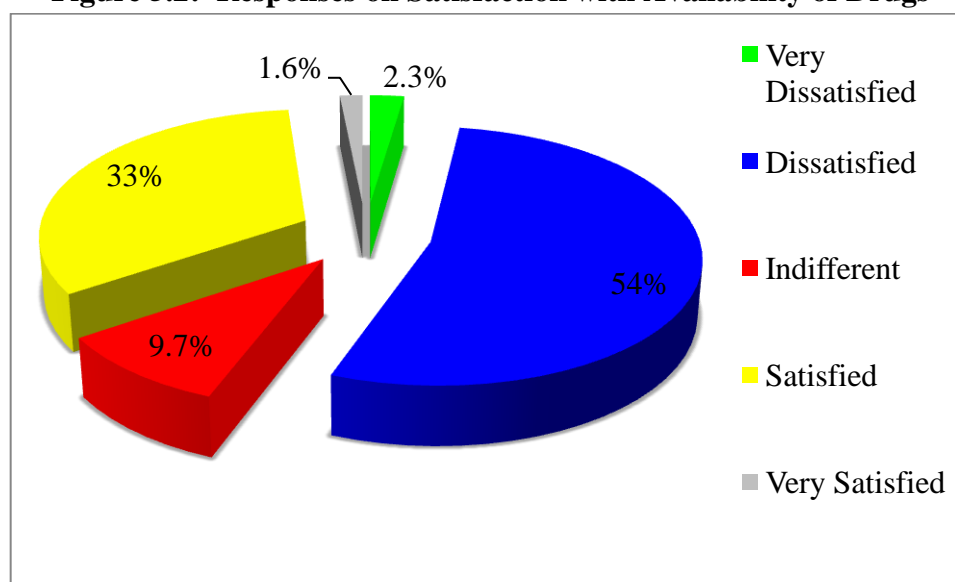
SATISFACTION WITH AVAILABILITY OF DRUGS

Overall, users were asked to rate their satisfaction with regard to the availability of drugs at the Health Centre visited. The responses revealed that 53.5 percent of the users were dissatisfied with the adequacy of drugs at the health facility they visited. The majority of the users were dissatisfied because of being referred to private chemists to buy drugs. Below are some of the reasons that users gave to why they were dissatisfied with the drug situation at the Health Centre they visited: “*because I was told to the medicine*”, “*I*

bought the drugs”, “*I bought the medicine that was not available*”, “*Because I was made to buy the medicine*”, “*Because I was referred to the pharmacy*” “*Because i was still made to pay for my own medication*” and “*Because we are made to buy the prescribed drugs*”. This study found that although expressed using different words but with the same meaning, lack of drugs had the strongest reactions of dissatisfaction by users.

However, it is also worth noting that 34 percent were satisfied with the availability of drugs at the Health Centre they visited. The majority of those that were satisfied are among the users that were given all the prescribed medication at the Health centre. This shows that the availability or non availability of some services or materials intended for users may have a direct influence on their overall experience.

Figure 5.2: Responses on Satisfaction with Availability of Drugs



Source: (Compiled Field Data, 2016)

It is worth noting that whether people paid the users fees or not, the responses reveal that the drug situation has not improved to the satisfaction of many users.

With respect to drugs in general, based on the responses, it can be argued that healthcare users did not classify the services offered at the Health Centres as free because they were required to buy their own medication (83.7 percent of users had to buy their own medication). This coincides with the view by Sjaak van der Geest et al (2000) who

argued that drugs are the overriding criterion by which patients judge the quality and cost of healthcare services.

CONCLUSION

UHCs had significant deficits in drugs that significantly limit their potential to provide health services to users. The main reason for ineffective drug availability was the increase in health services utilisation. The increase in utilisation was not accompanied by an increase in the quantity of drugs. The same quantity of drugs that were provided prior to the removal of user fees was still never changed after the removal of user fees. As such, 54.6 percent of the respondents did not find the drugs at the Health Centre's pharmacy. Users did not experience free services because the majority had to pay for drugs which were usually unavailable at the health centre's pharmacy.

Due to lack of drugs at health centres, users' experienced drugs costs at a private chemist of about K43.8. From their experience, most users could neither classify the health services at the health centres they visited as free, nor the drugs as given free of charge.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

This chapter provides a summary of the findings in relation to each general and specific objective of the study. It presents the experiences of users with regard to awareness, affordability, availability of drugs, availability of human resource, cleanliness of health facilities, time, professionalism and quality treatment of users by health personnel after user fees were removed (2012-2014). The chapter also provides recommendation thereof.

With regard to charges encountered at health Centres after the removal of user fees, the study concluded that 93.9 percent of the respondents said they were charged for registration. The amount charged for registration was K1. However, the K1 registration charge only applied to first time users who did not have a medical record with the Health Center. As such, it was once off payment unless a user lost their book or card. 38.5 percent of the users reported that they were charged for laboratory tests. 52.4 percent said that they were charged to undertake an x-ray test. Only 4.6 percent said they were charged for consultation.

The study concluded that any charge to users encounter entails non adherence to the user fee removal policy. The study further concluded that in comparison to studies done in rural areas such as the study by Masiye et al (2008), Rural Health Centres seem to have strictly adhered to the no user fee policy as compared to Urban health Centres where some users reported having been charged health care services that are to be provided free of charge such as registration. With emphasis placed on diagnosis that involves laboratory tests and X-ray tests in the delivery of quality health care to ascertain the causes of a users health condition, users encountered some charges, especially when Health Centres did not have materials for x-ray services which were usually provided through the use of flexible financing from user fees which is now nonexistent because of its removal. The effect on the removal of user fees affected the effectiveness of Health Centres to continuously provide services because grants were sometimes not paid on

time. Users as recipients of healthcare had sometimes experienced interrupted health care delivery.

Other financial charges reported by respondents, included the haemoglobin test (0.8 percent), Medical Report (1.5 percent) and Scanning services (3.5 percent). It is important note that these charges do not fall in the primary health care services package and as such, they were still chargeable even after the removal of user fees at both primary and secondary health care delivery systems.

In addition to financial charges, some users experienced encountered in kind charges. 18.1 percent of the respondents were requested to provide gloves, 16.2 percent provided their own injection syringe while 22.3 percent of had to provide their own sanitizers. The findings revealed that the removal of user fees had incapacitated health centres and have thereby shifted the cost burden of supplies for health care delivery at Health centres to the users. However, delivery services do not fall in the free primary healthcare package.

In relation to waits at the health centre, the responses revealed that users spent 2 hours (110 minutes) waiting to be attended to at a health centre. This implies that they spent more than 48 minutes above the time that users experienced before the removal of user fees. This Ministry of Health (2007) reported that waiting times for Urban Health Centres was 62 minutes. Long waits have been known to lead to increased worry, anxiety, stress and pain. Despite the increase in waiting time, the responses imply that there is an increase in the number of users who felt that the waits are reasonable. 44 percent said the waits were moderately acceptable while 29.9 percent said the waits were acceptable. Further, the responses revealed that on average, users spent 3 hours (172.03 minutes) as the overall time at the health centre. The majority of the respondents (44.32 percent) spent between 1 to 3 hours at the health centre. Only 2.7 percent of the respondents said they left the health centre within thirty (30) minutes of their arrival at the health centre.

The study concluded that the long waits were closely associated to opening time of health centres. Respondents that reported earlier than the opening time experienced a

longer waiting time. Further, users that are subjected to long waits may shun utilising Health Centres. But because health services are free, there were as many users that utilised healthcare services, as well as those that did not utilise healthcare services due to long waits.

The study concluded that there were substantial differences in experiences of waiting time and overall time spent at the health centers between Chelstone and Mtendere Health Centre users. As a result of the longer waits at Mtendere health centre, some users in Mtendere utilised services from other Health Centres such as Kalingalinga and Chainama. The study attributed mean difference in waiting time to the high density nature of Mtendere. Because Mtendere is characterised by unplanned settlements, it was more likely that the health centre was overcrowded because the levels of utilisation were beyond its infrastructural and human resource size.

With regard to drugs and medicines, UHCs had significant deficits in drugs and that significantly limit their potential to provide health services to users. The main reason for ineffective drug availability was the increase in health services utilisation. The increase in utilisation was not accompanied by an increase in the quantity of drugs. The same quantity of drugs that were provided prior to the removal of user fees was still the same after the removal of user fees. As such, 54.6 percent of the respondents did not find the drugs at the Health Centre's pharmacy. Recognising that fees are a barrier to accessing healthcare is one problem, removing user fees to increase utilisation is meant to redress the financial barrier. But, providing the same quantity of medication after the fee removal may be seen as an oversight on the effect of actions undertaken. Although affordability and access is a key determinant in the improving access to medicines, its availability, adequacy and sustainability in its provision are also required. The implication of free drugs was seen as a moral hazard because users visited Health Centres to collect drugs at no fee. The lack of responsibility by users also contributed to the depletion of drugs at health centres.

Users did not experience free services because the majority had to pay for drugs which were usually unavailable at the health centre's pharmacy. Thus, due to lack of drugs at

health centres, user's experienced drugs costs at private chemists of about K43.8. From their experience, most users could neither classify the health services at the health centres they visited as free nor the drugs as given free of charge.

The study concluded that 86.7 percent had never experienced a time when there was no one to attend to them. The responses revealed that about three quarters of the users experienced inadequate staff at the Health Centre they visited (74.2 percent). Effective diagnosis and provision of information to users can be hampered by poor doctor-patient ratio. The responses revealed that the majority (82.9 percent) of the respondents wanted the government to continue providing free healthcare services because the majority of Zambians are poor. 17.5 percent of the respondents had a bad experience of care after then removal of user fees. On the whole, there more users that expressed gratitude that they were able to find professional and compassionate care even if they were poor.

The study concluded that there was a difference in most of the cases between the experiences by users of Chelstone Health Centre and those that utilised the Mtendere Health Centre. The study also concluded when a government implements the removal of user fees policy face a double challenge on one hand how to increase utilisation and on the other, how to meet the demand of the increase in utilisation.

RECOMMENDATIONS

The study therefore recommends that:

- i) Strict adherence to no fee is also essential as some services were still being charged.
- ii) There is need to build more health facilities because both Mtendere and Chelstone Health Centres are providing healthcare services to more than its designed specification of 50, 000. Both health centres were providing to about double is designed capacity which may have been contributing to the long waiting times.

- iii) There is need to ensure drugs availability at health facilities because its lack thereof increases the cost of healthcare and thereby defeating the purpose of the removal of health user fees.
- iv) The government should link user fee exemption policies with the replacement of lost earnings and additional resources of facilities to ensure that there is uninterrupted service provision to users. With the removal of users fees, the Lusaka District Health Office should be consistent and on time in its issuance of imprest and grants since the primary healthcare facilities now solely depend on the government, delay of these payments cripples the effectiveness of health centres to provide for care to users;

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APPENDICES

Appendix A: USERS QUESTIONNAIRE

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES
USER'S QUESTIONNAIRE

Title:

Users experience of Primary Healthcare Services after the Removal of User Fees: A study of Chelstone and Mtendere Townships (2012-2014)

Dear Respondent,

This study is a being done to obtain information from recipients of rimary healthcare services users/patients in order to document their experiences after the removal of user fees. The study is completely for academic purposes and therefore, your name will not be used and your participation is voluntary. It will be appreciated if you answered all the questions to the best of your ability and knowledge. Further, you can skip any questions that you do not want to answer. It is estimated that the questionnaire will take about 15 minutes to complete.

Thank you for your time.

DATE: ____/____/2015

BACKGROUND INFORMATION

This information will help categorizing the user's responses into different contexts, and show whether different groups of people have different requirements

1. What is your Age as at last birthday?

2. What is your sex?

Male ☐ 1

Female ☐ 2

3. What is your marital status? *(Please tick one box)*

Never married..... ☐ 1

Married..... ☐ 2

Divorced..... ☐ 3

Separated..... ☐ 4

Widowed..... ☐ 5

4. What is your highest level of education? *(Please tick one box)*

Primary

Secondary

College

College

University

Postgraduate

certificate

certificate

Certificate

Diploma

Degree

Degree

☐ 1

☐ 6

☐

☐

3 ☐

☐

5

6

5. How would you describe your own current situation?

(Please tick one box)

Employed..... ☐ 1

Unemployed..... ☐ 2

Retired..... ☐ 3

Student..... ☐ 4

Other *(please write below what it is)*..... ☐ 5

.....

6. What is your average monthly income?

(Please tick one box)

K50-K500..... ☐ 1

K501-K2000..... ☐ 2

K2001-K5000..... ☐ 3

K5001-K10, 000..... ☐ 4

Above K10, 000..... ☐ 5

7. How long have you lived in this area? *(Indicate the number of years/months)*

Years

Months

ACCESS:

The ability to obtain patient- or client-initiated needed care (including advice and support) from the health provider at the nearest clinic within ones catchment area (after the user fee removal

8. Have you used the services of the nearby public clinic in the past three years?
Yes ☐ 1 No ☐ 2 (if NO, Ask for a household member that has utilized the services of the clinic/ end the interview if no one has utilized the services)
9. If Yes in Q7, about how many times have you visited the nearby clinic in the past three (3) years?
.....
...
10. Did you visit the nearby clinic before the past three (3) years (2011 and years before)

Yes ☐ 1 No ☐ 2

FINANCIAL COSTS AND DRUGS ACCESSIBILITY:

The extent to which direct or indirect costs related to care impeded access to needed care or prescribed drugs or may affect satisfaction of the healthcare received (after removal of user fees

11. Do you know what health user fees are?
Yes ☐ 1 No ☐ 2
12. Do you know that user fees for primary healthcare services were removed in 2012?

Yes ☐ 1 ☐ 2
13. Did you have to pay for any of the following services in your visit to a nearby public clinic during your visit/s in the past three years? (Please tick one box for each service)
- | | Yes | No |
|--|----------------------------|--------------------------|
| Registration (buying a book/card)..... | <input type="checkbox"/> 1 | <input type="checkbox"/> |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> |
| Consultation..... | <input type="checkbox"/> 1 | <input type="checkbox"/> |
| 2 | | |

	X-ray.....	1	
2			
	Admission.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	To see a regular Doctor/clinic officer.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	To see a Specialist Doctor.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	Laboratory tests (e.g. Malaria Test).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
	Other, (please write below what it is).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
		
		

14. In the past three (3) years, was there/were there times when you did not receive the following services because of their costs? *(Please tick one box for each service)*

		Yes	No
	Registration (buying a book/card).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
	Consultation.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	X-ray.....	1	
2			
	Admission.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	To see a regular Doctor/clinic officer.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	To see a Specialist Doctor.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
	Laboratory tests (e.g. Malaria Test).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
	Other, (please write below what it is).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2			
		
		

15. In the past three (3) years, has the clinic or staff at the clinic asked for any of the following in-kind payments? *(Please tick one box for each type of in-kind payments)*

Yes	No
-----	----

2	Gloves.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2	Injection Syringe.....	<input type="checkbox"/> 1	<input type="checkbox"/>
2	Sanitizers (soaps, Jik).....	<input type="checkbox"/> 1	<input type="checkbox"/>
2	Other, (<i>please write below what it is</i>).....	<input type="checkbox"/> 1	<input type="checkbox"/>

16. In the past three years, how did you travel to the clinic? Please choose the kind of transport that best describes how you travelled from your home to the clinic. If you used more than one form of transport please indicate the way you travelled for the main (longest in terms of distance) part of your journey.

Walked.....	<input type="checkbox"/> 1
Cycled/ Motorbike.....	<input type="checkbox"/> 2
Taxi.....	<input type="checkbox"/> 3
Bus.....	<input type="checkbox"/> 4
Private car.....	<input type="checkbox"/> 5
Ambulance.....	<input type="checkbox"/> 6
Other, (<i>please write below what it is</i>).....	<input type="checkbox"/> 7

17. If you travelled by public transport (bus or Taxi), used a motor cycle or Private car for the longest part of your journey in terms of distance, what was the cost of the one-way and two way fare? Please write the cost below. Put zero if you did not incur any transport costs.

Cost of one-way fare.....	K	<input type="text"/>
Cost of two way fare.....	K	<input type="text"/>

18. In the past three (3) years, did you ever experience demand for bribes to receive a service? (*For example, being asked to pay gratification so as to be attended to faster*)

Yes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
-----	----------------------------	----------------------------

19. During the past three years, overall, have you encountered the problem of fees being too expensive with your local public clinic?

Yes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
-----	----------------------------	----------------------------

20. In your visit to the clinic in the past 3 years, did the doctor or clinic officer write you a prescription at that visit/s?

Yes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
-----	----------------------------	----------------------------

21. *If Yes in Q23*, was the prescribed medication available at the clinic pharmacy?

Yes ☐ 1 ☐ 2 *If No in Q23, skip to Q26*

22. Was the medication given at the public clinic adequate?

Yes ☐ 1 ☐ 2

23. Did you have to pay for the prescribed medication?

Yes ☐ 1 ☐ 2

If Yes to Q25, how much did you pay?
K.....

24. When there were no drugs at the clinic, did you buy the drugs from a private chemist or drug store?

Yes ☐ 1 ☐ 2

If Yes, How much did you pay for medication at a private chemist?

K.....

25. Overall, during the past three (3) years, was there a time/were there times when you did not take medicines prescribed by a doctor because of their costs?

Never ☐ 1 Rarely ☐ 2 Sometime ☐ 3 Oft ☐ 4 Very oft ☐ 5 I don't remember ☐ 6

26. In your experience in the past three years, would you classify medication as being given 'free of charge' at the public clinic you visited?

Yes ☐ 1 ☐ 2

27. Overall, how would you rate the clinics' effectiveness with regard to the availability of drugs at the clinic you visited in the past three (3) years?

Very Ineffective ☐ 1 Ineffective ☐ 2 Indifferen ☐ 3 Effecti ☐ 4 Very H ☐ ive 5

28. In your experience in the past three years, overall, would you classify health services as being offered 'at no fee' or 'free of charge'?

Yes ☐ 1 ☐ 2

Give a reason for your answer.....

29. Overall on cost-effectiveness, how affordable were healthcare in the past three (3) years?

Not at all Affordable ☐ 1 Not Affordable ☐ 2 Indifference ☐ 3 Affordable ☐ 4
Very Affordable ☐ 5

WAITING TIME:

The ability of the primary care organization and practitioners to provide care within a time frame appropriate to the urgency of the problem after the removal of user fees

30. How long did it take to travel from your home to the clinic?

Hour/s Minutes

31. In the past 3 years, how often did doctors/clinic officers or other health providers spend enough time with you? *(Please tick one box)*

Never..... ☐ 1
Sometimes..... ☐ 2
Usually..... ☐ 3
Always..... ☐ 4

32. In your experience: on average, Estimate the time it took to:

	Hours	Mins
Get test results from the laboratory.....	<input type="text"/>	<input type="text"/>
Get an X-ray.....	<input type="text"/>	<input type="text"/>

33. On average, on the time/s you utilized the health center, how long did you have to wait before you could see a doctor, clinical officer or nurse?

Hours Minutes

34. On average, how can you describe your visit to the nearby public clinic in the last 3 years?

(Please tick one box)

Too Short..... ☐ 1
Too Long..... ☐ 2
☐

Just right..... 3

35. Overall, how long did you spend at the clinic? Please include in your answer the time spent waiting and also the time spent with the clinic officer, doctor or nurse).

Hours Minutes

36. How do you rate the time spent at the clinic?

Not acceptable at all	Not very acceptable	Moderately acceptable	Acceptable	Very
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADEQUACY OF PERSONNEL:

The information collected here will used to analyze the availability of staff after the removal of user fees

37. In the past three (3) years, have you experienced an absent clinic officer or doctor?

Yes ☐ 1 ☐ 2

38. In your experience in the last three years, has there been a time when you were told that there is no doctor or specialist to deal with your case?

Yes ☐ 1 ☐ 2

39. In your experience, are there adequate personnel to attend to patients at the clinic?

Yes ☐ 1 ☐ 2

40. During the past three (3) years, were there times when persons from your clinic seem to work tired? (Please tick one box)

Never..... ☐ 1
Sometimes..... ☐ 2
Often..... ☐ 3

Often..... 3

41. Overall, please show how good or bad your experience of care was by circling the number on the scale below

Worst experience 0 1 2 3 4 5 6 7 8 9 10
Best Experience
of care ←————→ **of care**

42. If Yes to (Q10) [i.e. having visited the nearby clinic before the past three (3) years (2011 and years before)], has healthcare provision improved after the fee removal?

Worsened Significantly..... ☐ 1
 Worsened..... ☐ 2
 Remained the Same..... ☐ 3
 Improved..... ☐ 4
 Improved Significantly..... ☐ 5

43. Should the government continue providing free primary health services?

Yes ☐ 1 ☐ 2

Give a reason for your

answer.....

.....

.....

What should the government do to improve the provision of health services?

.....

.....

.....

Thank You for your Participation

Appendix B: INTERVIEW GUIDE

The University of Zambia
School of Humanities and Social Sciences
Department of Political and Administrative
Studies
P.O Box 32379
Lusaka.

January 10, 2017

Chelstone Health Center
Ministry of Health
Lusaka

Dear Sir/Madam,

RE: REQUEST TO CONDUCT AN INTERVIEW

I am a student at the University of Zambia pursuing a Masters in Public Administration. I am conducting a study on *Users experience of Primary Healthcare Services after the Removal of User Fees: A case of Chelstone and Mtendere Townships (2012-2014)*. Your name/position has been identified to be among the sample to be interviewed.

The purpose of writing is to request for your agreement to be interviewed. If granted, the interview will take about fifteen minutes of your time on a date and time to be agreed. The study results will be used for academic purposes and therefore, individual results of this study will remain absolutely confidential and anonymous. When this study is published, only the results will be documented.

Your acceptance to participate in this study will greatly be appreciated.

If you agree, kindly sign below

I hereby agree to participate in the research entitled: *“Users experience of Primary Healthcare Services after the Removal of User Fees: A case of Chelstone and Mtendere Townships (2012-2014).”*

Signature:Date:
Interview Guide

Background

What is your position at this clinic?


How long have you worked in this position?

How long have you worked at this clinic?

Health services Provision

1. Are you aware of the removal of health user fees?
2. Can you estimate the actual period (year/month) in which the removal of user fees was effected at this health institution?
3. Are there any **activities or services** that are offered at this institution which users still have to pay for?
4. Have you seen any **change in the way health workers relate to users** after the removal of user fees
 - i. time spent with patients
5. What has been your observation with regard to **user's access to prescribed drugs** after the removal of user fees at this institution?
6. In your observation, has the removal of user fees resulted in any **significant impact on workers workload** at this health institution due to increased utilization by the users?
7. Are there any **challenges that users now face** at the health facility after the removal of user fees?
8. Are you aware of any **programmes, activities or services** that were previously funded by user fees that are still running or that have ceased since the removal of user fees?
9. In the past three years since the removal of user fees, has there been a **consistency in funding from the government** for the provision of health services?
10. Have there been any **mechanisms by the government** that have been put in place to cushion for the income that was generated through user fees.
11. Do you think the government should continue providing free health services?
Why?
12. Any important information on removal of user fees in relation to this health facility

Appendix C: ETHICAL CLEARANCE


THE UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: 260-211-280258/293937
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P O BOX 32379
LUSAKA, ZAMBIA

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23rd April, 2015

Mr. Tambulani Chayima Nyirenda
C/o School of Humanities and Social Sciences
Department of Political and Administrative Studies
University of Zambia
P.O Box 32379
LUSAKA
ZAMBIA

Dear Mr. Nyirenda,

Re: EXEMPTION FROM FULL ETHICAL CLEARANCE

With reference to your research proposal entitled:

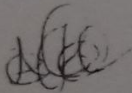
"The Effectiveness of Healthcare Services after the Removal of User Fees: User Experiences in Chelstone and Mtendere Townships (2012-2014)."

As your research project does not contain any ethical concerns, you are hereby given an exemption from full clearance to proceed with your research.

ACTION:	APPROVED
DECISION DATE:	23 rd April, 2015
EXPIRATION DATE:	22 nd April, 2016

Please note that you are expected to submit to the Secretariat a Progress Report and a copy of the full report on completion of the project.

Finally, and more importantly, take note that notwithstanding ethical clearance given by the HSSREC, you must also obtain authority from the Permanent Secretary Ministry of Health, before conducting your research. The address is: Permanent Secretary, Ministry of Health, Ndeke House, P.O Box 30205, Lusaka. Tel: 260-211-253040/5; Fax +260-211-253344.


Dr. Mildred Nkolola-Wakumelo
CHAIRPERSON, HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc: Director, Directorate of Research and Graduate Studies
Assistant Director, Directorate of Research and Graduate Studies
Assistant Registrar (Research), Directorate of Research and Graduate Studies